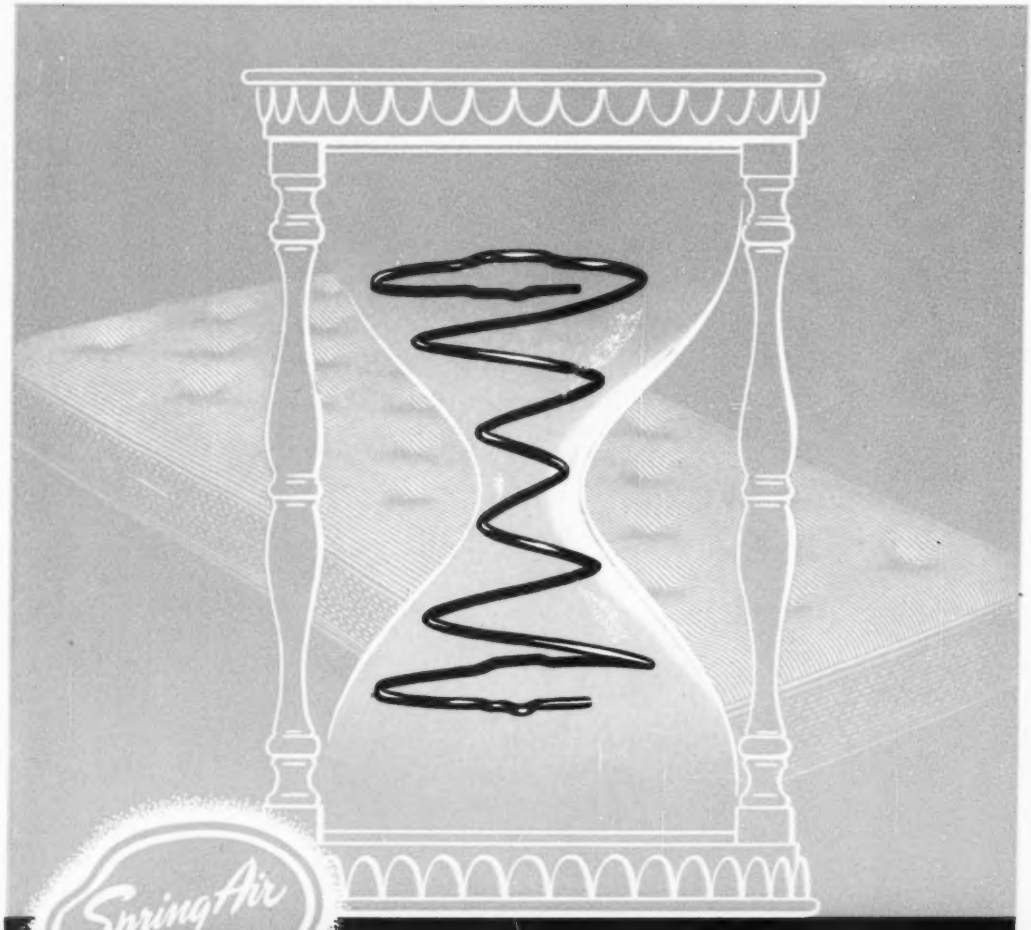


The Modern Hospital

JUNE 1949

Hospitals under socialized medicine • Treatment of poliomyelitis in the general hospital • Principles and technics of admitting patients • Advantages of hospital licensure • Helpful hints on medical records • Big issues facing hospital trustees



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JUNE 1949

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AMONG THE AUTHORS



Dr. Joseph G. Molner is deputy commissioner and medical director of the Detroit health department, with which he has been connected in one capacity or another for more than 20 years. He is also associate professor of public health and preventive medicine at Wayne University College of Medicine, from which he was graduated in 1935. A medical consultant to the National Foundation for Infantile Paralysis, Dr. Molner has written a number of papers on administrative and epidemiological aspects of poliomyelitis, about which he writes in this issue of The Modern Hospital—page 56.



Alma M. Troxell is superintendent of the Oil City Hospital, Oil City, Pa., a position she has held since 1935. Prior to that time she served for several years as director of nursing at the hospital. She is a graduate of the State Hospital School of Nursing at Scranton, Pa., and is active in nursing, hospital and related association activities. At present, Miss Troxell is a trustee of the Pennsylvania Hospital Association and a member of the boards of local Red Cross, cancer and tuberculosis organizations. Her article in this issue of The Modern Hospital describes a physical therapy department for a small hospital; it appears on page 73.



Now assistant director of the Beth Israel Hospital in Boston, Mass., **Sidney Liswood** is a graduate of the University of Chicago course in hospital administration. He served his administrative internship at New Haven Hospital, New Haven, Conn., in 1942, then entered the army as a private. At the time of his discharge from service in 1946 he was a captain in the medical administrative corps and commanding officer of the 7th medical depot company. His article on page 72 of this magazine describes a group diagnostic service that he has helped to organize and direct at the Beth Israel Hospital.



Charles A. Lewis, who describes a service for premature infants on page 78, is an administrative assistant in the information service, or public relations department, at Detroit's Wayne University. Following graduation from the University of Michigan and graduate work at Wayne before the war, he worked at Wayne for several years before joining the army. He served as public relations officer of the 16th corps in France and did similar duty at Camp Grant, Ill., and Sixth Service Command headquarters in Chicago. Mr. Lewis left the army as a major in 1946.

Frank L. Simons, who collaborated with Mr. Lewis in writing the article, "A Preemie's Progress," is a senior in journalism at Wayne and one of the nation's busiest undergraduates—part-time staff member of the *Detroit News*, night editor of Wayne's *Detroit Collegian*, and assistant in university press relations work.

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Roving Reporter

Questions Asked and Answered

Prime purpose of a patient's handbook is to answer the ordinary questions that arise in the minds of most patients. It has taken University Hospitals of Cleveland, however, to display these questions as subtitles for its new booklet entitled "You, the Patient."

Printed on bright canary stock and illustrated with humorous line drawings, this snappy booklet gives concise answers to these questions:

When do I eat?

Why are the nurses so busy?

Why was it so difficult to get a bed?

Who owns the hospital? Who runs it?

What is meant by "community service"?

Why do hospitals cost so much?

What do I buy with each dollar I spend for hospital care?

What entrance should my visitors use?

Where should one come for emergency treatment?

Where should I come to be admitted?

Why can't I have all the visitors I want?

What goes on behind the scenes?

When can I go home?

Dr. W. B. Seymour, director of administration, has done the foreword to the booklet. There is a center pictorial spread, "Where Science and Mercy Meet," and near the end is a perforated page calling for suggestions or criticism of the care received. The patient is asked to tear out the page and give it to the head nurse who will forward it to the director of administration. "Your compliments will be welcomed as well," this page says adroitly in parentheses.

There is nothing so crude as a blank space for donations, but near the end is a short section called "For a Brighter Tomorrow," which says: "We feel we would be remiss in not apprising you of the opportunity which is always present and in which you may participate if you desire to do so. Anyone wishing to aid in this most worthwhile work should call or write the director of administration."

The booklet is given to private patients by the head nurse at the time of her initial visit.

For Better Communication

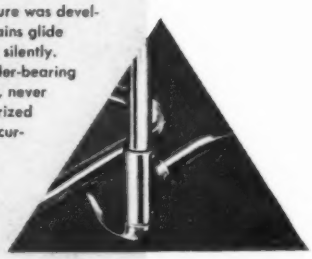
It isn't too soon for professional schools and hospitals to be exploring the possibilities of new communications media, such as television and telephone, in both postgraduate and popular instruction.

The University of Illinois College of Dentistry is pioneering in round-table discussions and symposiums by long distance telephone, and the boards of education of Philadelphia and of Cam-

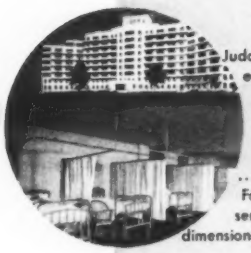
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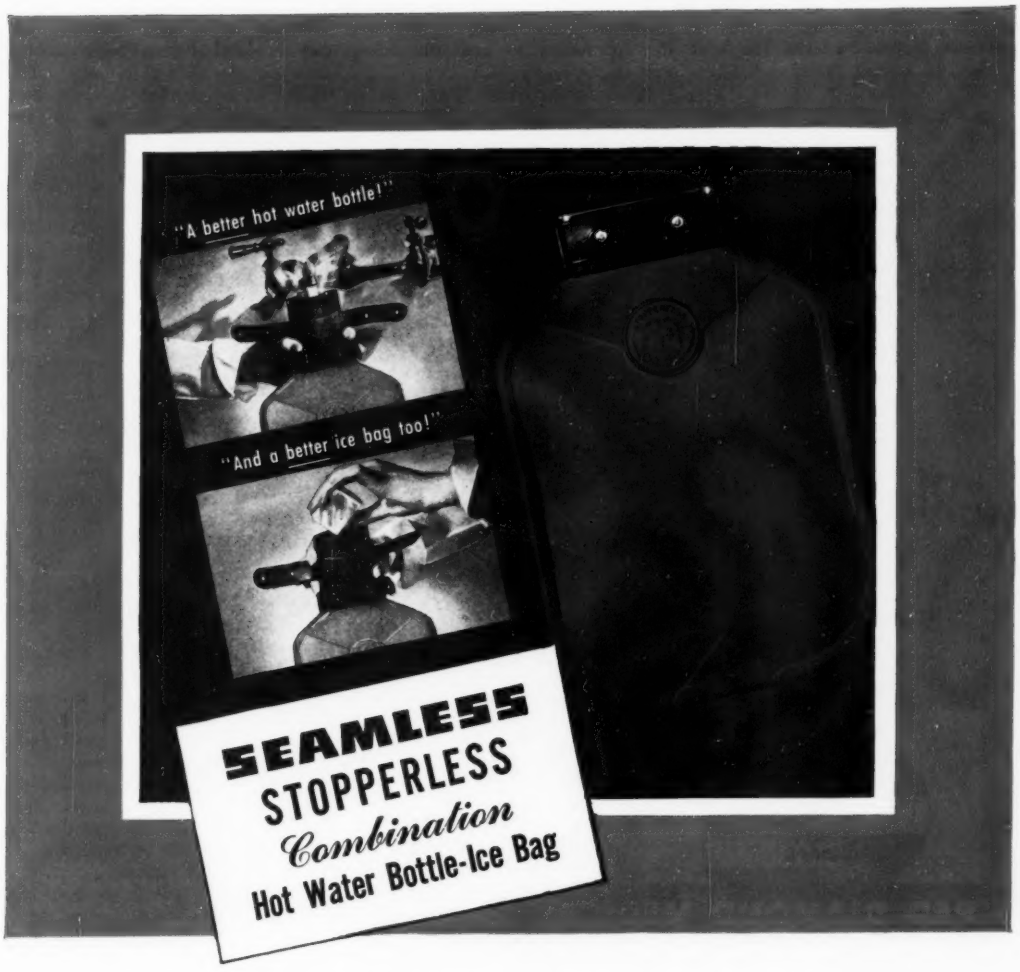
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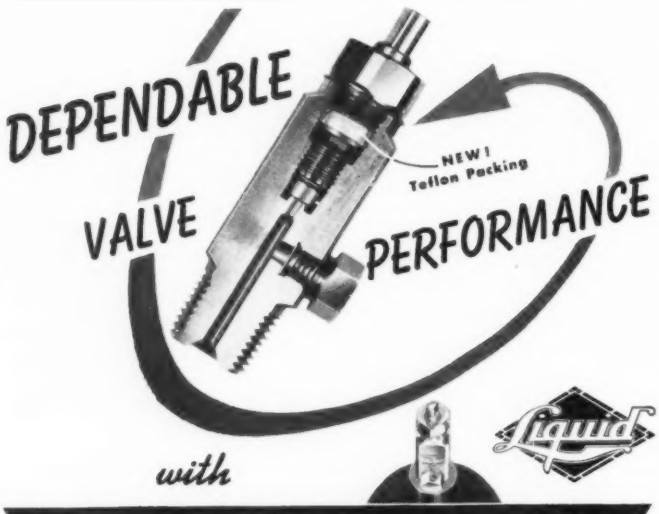
den, N.J., are exploring the rôle of television in public schools. The latter project is entitled "Operation Classroom."

The University of Illinois, after two years of successful experimentation, will present a series of round-table discussions on "Current Advances in Dentistry," a monthly two-hour program for interested dental societies. The programs will take place in October and November of 1949 and in the first four months of 1950. A coast-to-coast transmission, it is aimed especially at dental groups in rural areas and in small communities that usually do not have the opportunity to hear outstanding men in the profession.

Lantern slides shown in conjunction with the series will be sent by the university to all participating groups. Brochures and other material will also be furnished.

This university has found that the cost of telephone transmission of lectures is low. Each society participating in the program pays a set fee for the course. The American Telephone and Telegraph Company has charge of all technical details and guarantees clear, unbroken transmission. Standard toll calls are placed between Chicago and the cities signing up for the series. The telephone transmission is then "ballooned" over a loud-speaker to the groups gathered in distant cities.

In the television experiment in Philadelphia and Camden, the weekly telecasts are covering a wide variety of subjects so as to determine which can be most effectively taught by television. Schools of nursing, hospital administration, and allied educational enterprises can well watch the results of these comparative studies for possible use in extension work on the graduate or popular level.



Liquid's introduction of the Liqua-Seal, *leak-proof* valve, puts Red Diamond Medical Gas cylinders far out in front for satisfaction and service. Important design features — plus the use of Teflon, the "miracle plastic", as a washer-seal — assure smooth, effortless valve operation. Re-designed two-piece stem seat avoids annoying friction. Heavier compression spring maintains constant pressure on Teflon packing. Ball-bearing movement contributes to easier valve opening and closing... A Valve as high in convenience as Red Diamond *Gases* are in purity.



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College Is Necessary

That a minimum two years of college is necessary as a prerequisite for professional training in nursing if the schools are to turn out the type of "well rounded, adjustable and resourceful individuals needed for nursing" is the view expressed by Dean Francis H. Horn of McCoy College, Johns Hopkins University, addressing the first graduating class to receive a B.S. degree in nursing from Hopkins.

Nor will it be hard to find such young people, in Dean Horn's opinion. By 1960, he believes, free public education through the fourteenth year will be provided for the great majority of young people in most states. Then nursing schools will get junior college graduates as readily as they now get high school graduates.

"If nursing is to attain the status that it should have in our new world, if nurses are to be well fitted for their greater responsibilities, then all professional nurses must be college women," Dean Horn declared.

"It is incumbent upon those in the nursing profession to work toward the acceptance of this point of view. It is incumbent upon those of us in institutions of higher education to make the realization of this ideal possible."

Scholarships for Male Nurses

Though the need for male nurses is of long standing, Adelphi College, Garden City, N.Y., is one of the few schools that has thought to offer scholarships to men as well as to girls. And even Adelphi did not think of it until recently.

High school graduates, both male and female, had until May 15 to apply for the five scholarships available: one at $500 a year; one at $350; one at $200, and two at $100.

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Reader Opinion

Badges

Sirs:

Your editorial, "Can't Tell the Players," in the April issue intrigues me. First, let me say that as the immediate past president of the New England Hospital Assembly, the oldest regional association in the country, I am fully in accord with the suggestion of the Hospital Industries Association.

I have seen a system of colored badges adopted in a modified manner by the New England Assembly after having worked as its secretary for a period of ten years; after having taken the responsibility of inviting on a cooperative basis a certain few exhibitors to bring their supplies to show the attending hospital administrators, and after having lived through the period of progress to the point of originating the idea of extending a special invitation to the trustees of member hospitals to attend a day-long session dedicated solely to their problems. The first attempt at setting up a trustees' institute was amusing in that many of the administrators were apprehensive lest their trustees gain information not disclosed to them previously, and many of the trustees were timid about participating in any open session where they were permitted to take out a pin or two and let a little of their hair down.

Returning to the suggestion of the Hospital Industries Association, I do take exception, perhaps through my naïveté, to assigning mouse-colored badges to minor department heads. I would much rather have them wear a white badge—a symbol of pure territory uncontaminated by the machinations of trustees, administrators, their assistants, major department heads, et al., including consultants and exhibitors.

As to your suggestion that the "thirsty convention goers" be tagged with a special brown blotting paper badge, I would like to recommend to the "ever-loving exhibitors" that the invitations to their gatherings be printed on similar material, namely, beautiful, scented, brown blotting paper. After all, if one wishes to browse through the various affairs, one needs some substance on hand to dry up the fluid characteristic of this form of hospitality.

The New England Hospital Assembly, on the observance of a quarter century of meetings, established a reception prior to its annual dinner. To put it bluntly, the purpose of this move was to discourage any private parties, whatever their nature, on that particular evening. A letter to this effect was sent to all exhibitors. Past experience proved that these "private thirsty parties" detained a certain number of individuals who had intentions of attending the annual dinner but always arrived late, to the consternation of the master of ceremonies (on whose shoulders rests the thankless responsibility for the success or failure of a meeting). The disapproval of others who assembled for the "pièce de résistance" of the annual meeting is still another point for consideration.

I may be wrong, but I believe that if exhibitors who employ "parties" as an aid to their selling efforts were refused space for displays at regional and national meetings, one would find that a distinct majority of administrators would favor the elimination of such sales arguments.

A. G. Engelbach, M.D.
Mount Auburn Hospital
Cambridge, Mass.

Boner

Sirs:

Will you chide your editorial staff for its slackness in describing the Effingham Hospital as "fireproof"? It was neither "fireproof" as used in the ordinary parlance of the layman nor in the sense used in the building industry; it was not even "fire resistive," the more technically correct expression to describe what the layman means by "fireproof."

No further proof is needed than the pictures you published and the terrible calamity that these represented.

An editorial correction is only proper.

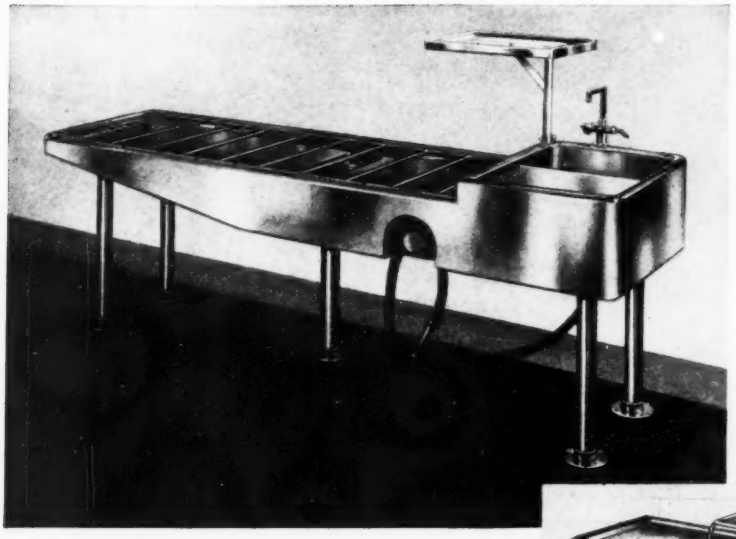
Carl A. Erikson
Schmidt, Garden and Erikson
Chicago

The Modern Hospital owes its readers an apology for perpetuating an obvious newspaper error.—ED.

For Efficient Performance

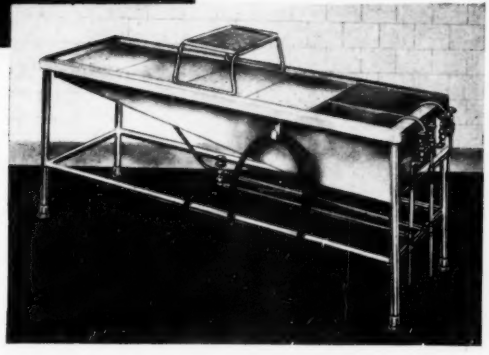
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• These modern, stainless steel autopsy tables are noted for their all-welded seamless construction and long service life. Fully-rounded corners and coves eliminate dirt-collecting crevices, make cleaning easy and assure maximum sanitation. Proper drainage facilities, convenience of operation and efficient arrangement of accessories are other features meeting widespread approval. Blickman autopsy tables are today rendering satisfactory service in many leading hospitals and institutions. We invite your inquiries.



Left: **HARTFORD Model**
In this model, the trough, foot-end sink and drainboard form a completely welded, crevice-free assembly which assures absolute sanitation and long service life. The crossbars are removable and rest on ledges which are perforated so that entire trough may be thoroughly flushed. The trough itself slopes from both ends to the sink in center. Removable stainless steel tray is mounted on adjustable standard.

Below: **BRUNSWICK Model**
An efficient unit, favored by many hospitals. Instrument tray slides along the perforated removable top. Trough slopes to the sink section at foot. All fluids flow directly from the cadaver into constantly running water . . . the entire bottom of trough being continually flushed by a concealed device. A choice-section sink—with hot and cold water supply—is at foot end of fixture, to hold organs reserved for later dissection. Table available with a one-section perforated top, instead of the four-piece top illustrated.

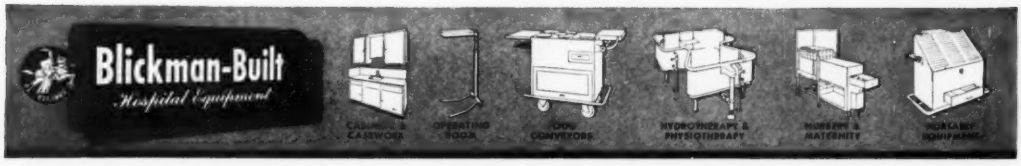


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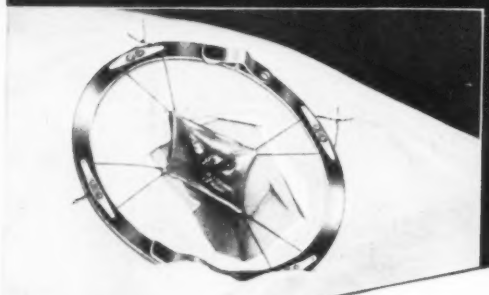
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affords unprecedented depth of exposure of the operative site to a degree which permits visualization of all varicosities in the hemorrhoidal area.

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*Helfrick, J. Rembrandt: Amer. Jour. Surgery 70-1:131-132, October, 1945



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T. Coull
Superintendent of Building

TC: MA

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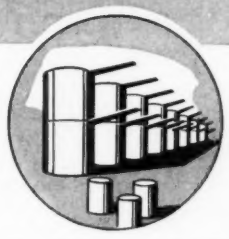
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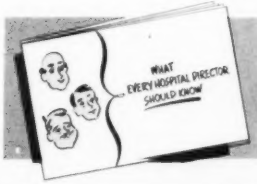
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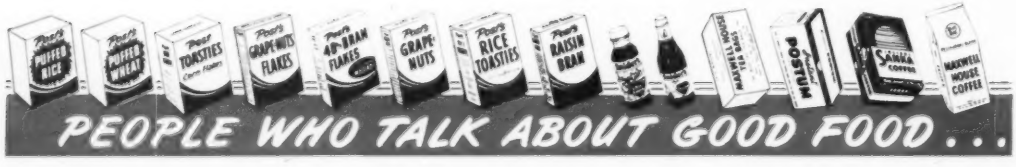
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with Spot-Film Facility

Both spot-film facility and X-Actron* electronic milliampere regulation are yours in the new Westinghouse diagnostic control—the Westex. The design is such that you secure completely automatic operation with minimum investment.

Only three main controls are used. The "Technique Selector" permits selection of stations and operational circuits for radiography, therapy, or fluoroscopy (spot-film) while the "Large" and "Small" Kilovoltage controls allow choice of kv from 30 to 100. Indicator lights show the technique in use and two large, easily-read meters show kilovolts and milliamperes. Provision is made for using a 1/10-second synchronous timer or the Westinghouse combination electronic and synchronous timer with a 1/20-second minimum setting.

The Westex is another wall-mounted control following the widely-accepted Westinghouse X-Ray control design.

For full information on this latest Westinghouse control, see your local Westinghouse X-Ray Specialist today. Or write Westinghouse Electric Corporation, P. O. Box 868, Pittsburgh 30, Pennsylvania. J-08214

*Trademark

Westinghouse X-Ray

Meat and the Management Of Macrocytic Anemias

A recent clinical study* on the efficacy of vitamin B_{12} in macrocytic anemias emphasizes the value of a diet high in complete protein in the general management of these conditions.

In addition to specific antianemia therapy "a diet rich in animal protein" is recommended as one of the principles of treatment in pernicious and related macrocytic anemias.

Meat deserves a prominent place in the dietary of these anemias. It is an outstanding source of complete protein, providing all the amino acids essential for blood formation and tissue repair. In addition to its notably high content of complete protein, meat is one of man's best natural sources of B-complex vitamins and iron.

The excellent digestibility of meat makes possible its use twice or more times daily when required by dietary demands.

---

*Spies, T. D.; Suarez, R. M.; Lopez, G. G.; Milanes, F.; Stone, R. E.; Toca, R. L.; Aramburu, T., and Kartus, S.: Tentative Appraisal of Vitamin B_{12} as a Therapeutic Agent, J.A.M.A. *139*:521 (Feb. 19) 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute

Main Office, Chicago...Members Throughout the United States

BUY BETTER BROILERS TOO

FROM THE LINE OF THE LEADER!

Only Garland gives you all the advantages of



Broils like no Broiler you've ever used before! Special long multi-jet burners—one on each side—spurt hot flames toward the center, heating the entire ceramic area when on "high." Ceramics radiate intense heat downward over entire grid, providing even heat distribution.

You raise or lower grid as desired by means of a lever control located outside the heat zone. Large capacity grid measures 24 inches wide by 26 inches deep. Oven is located above the broiling unit and heated by the same burners.

Compare—nothing on the market equals Garland value at the low Garland price. All Garland units are available in stainless steel and equipped for use with manufactured, natural or L-P gases. See your Garland dealer now.



Model pictured is **Garland Broiler No. 632**



The Garland Broiler is designed to fit efficiently and harmoniously in battery with other Garland units.

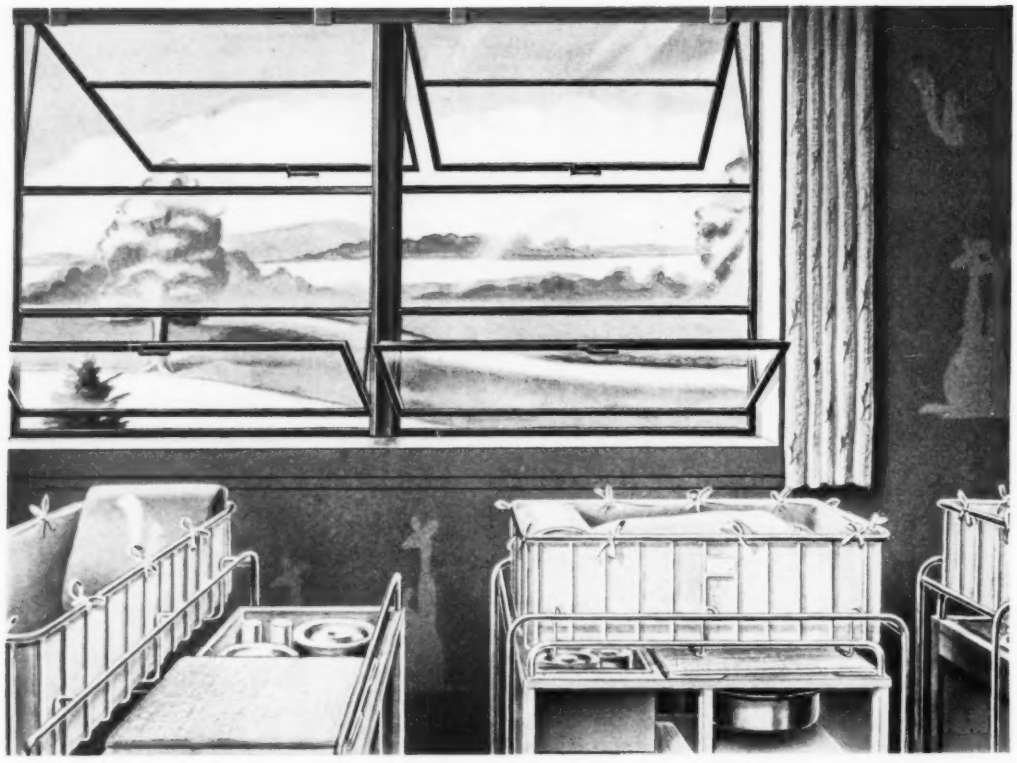
GARLAND*

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Heavy Duty Ranges • Restaurant Ranges • Broilers • Deep Fat Fryers • Toasters
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PRODUCTS OF DETROIT-MICHIGAN STOVE CO., DETROIT 31, MICHIGAN

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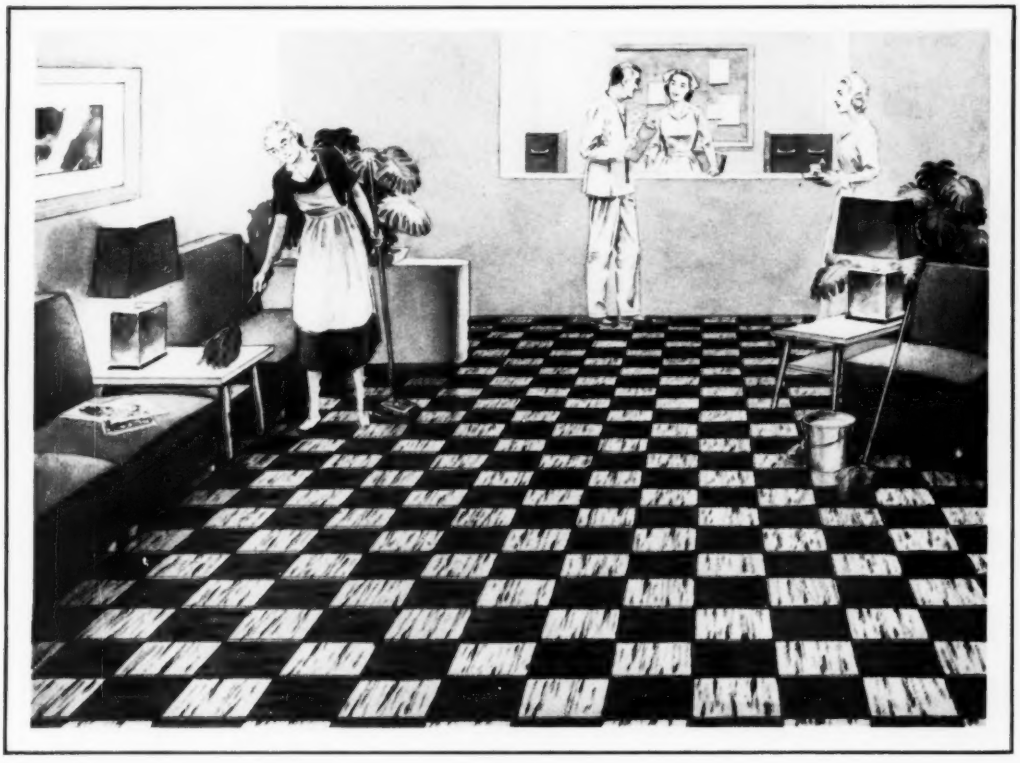
In nurseries, in convalescent rooms, in solariums — Lupton Metal Windows supply all the benefits of modern metal window design. Slender metal frames increase glass area, make rooms brighter, more cheerful. Controlled, healthful ventilation is assured with ventilators that open to any desired amount. Safe and always easy to operate. Your hospital architect knows Lupton Metal Windows — sturdy, long-lasting windows backed by more than 40 years of steel window design. Your builder knows Lupton Metal Windows—complete units save installation time and speed up building operations. The Lupton Representative will gladly give you full details. Or write for our General Catalog.

MICHAEL FLYNN MANUFACTURING CO.
700 East Godfrey Avenue, Philadelphia 24, Penna.
Member of the Metal Window Institute

LUPTON
METAL WINDOWS



"I've been on a month's vacation..."



"Imagine me getting a month's vacation! Well, actually I didn't in the true sense of the word, but I've been cleaning floors in this hospital for the past twelve years and last month new flooring was installed in all the rooms, corridors, the reception hall . . . everywhere. And believe me, cleaning these new floors is so easy compared to the old ones, it seems like a vacation. And in addition, they're so quiet, and the colors and designs do so much to make the whole hospital more attractive. Yes, the superintendent certainly made a wonderful choice. What was it? . . . Hood Rubber Tile!"

* * * * *

Yes, wherever flooring beauty, longer wear (14 years in a Massachusetts hospital), ease of maintenance and comfort are *so* important, the choice is Hood Rubber Tile. Write for free color catalog showing why leading hospitals everywhere use Hood Rubber Tile.

Hood Rubber Co.
A DIVISION OF
B.F. Goodrich
WATERTOWN, MASS.

HOOD—FOR RUBBER TILE **HOOD—FOR ASPHALT TILE**



Quiet is universally recognized as an important factor in aiding recovery. Yet in many hospitals, patients do not have the restful quiet they need. Because the countless sounds of everyday hospital routine are *unchecked*. They "pile up" into a constant, nerve-wracking din that disturbs rest and can actually retard recovery.

How about *your* hospital? Is noise "running wild"—irritating patients and putting needless extra strain on doctors, nurses, and service personnel?

If it is, do as thousands of hospitals all across the nation have done. Get a free analysis of your noise problem from your local distributor of Acousti-Celotex products. Let him show you how Sound Conditioning the modern way—by installation of Acousti-Celotex products—blots up noise and creates the quiet comfort you want in your hospital.

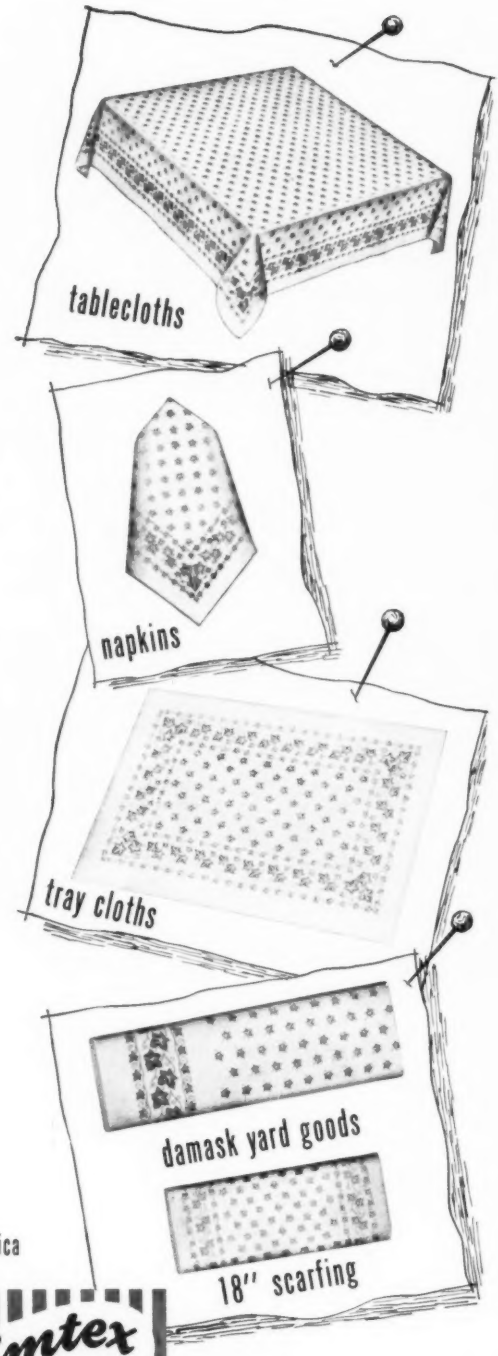
You can depend on this Celotex-trained technician. He is a member of the largest and most experienced Sound Conditioning organization in the country. He has the right materials for every noise problem. And his methods are backed by the "know-how" gained in making over 200,000 actual Acousti-Celotex sound-absorbing ceiling installations . . . more than any other company in the business!

Write us today for his name and a free copy of the informative booklet, "25 Questions and Answers on Sound Conditioning." The Celotex Corporation, 120 South La Salle Street, Chicago 3, Illinois.

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Dollar-for-dollar, MA • TI • CO asphalt tile will cost you less than that of any other applied type of flooring. Just shop . . . compare!
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Daily dusting and an occasional mopping and waxing is all you need to keep your MA•TI•CO floor clean and beautiful. MA•TI•CO is odorless, sanitary, safe . . . will not wear slippery with use.
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Because it is made to Federal specifications, MA•TI•CO tile must be right! In close to 200 million sq. ft. of installations, MA•TI•CO is proving its endurance to wear under the most rugged conditions.
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Should undue abuse or accident necessitate repairs, new MA•TI•CO tile units are easily inserted. Expansion of floor, as in remodeling, is just as simple with minimum disruption of normal store or plant operation.
. . . It's Factory-Waxed!
• 27 beautiful colors, plain and marbleized, including new pastel and decorator shades.
• They 'n' there colors can't rub off.
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• Resists moisture. Ideal for use over concrete when in contact with the ground.
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Simtex answers every requirement for HOSPITAL NAPERY



Whether it's Tablecloths and Napkins for staff dining rooms —Napkins and Tray Cloths for patients' meal service— scarfing for room furniture—or Damask Yard Goods— many experienced Hospital Buyers always specify SIMTEX because of these features:

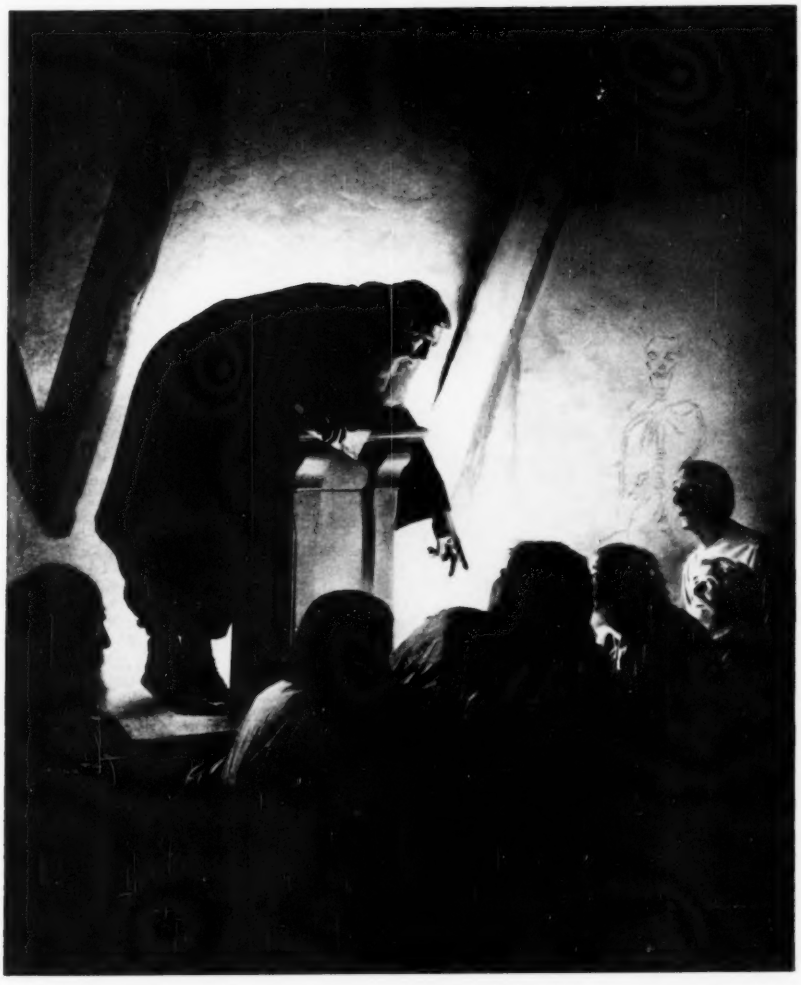
1. **BASCO FINISH:** *Only SIMTEX Napery has the celebrated permanent finish that permeates every fibre of the fabric.*
2. **LONG LIFE:** *SIMTEX cloths are famous for their serviceability, retaining their fresh beauty for a surprisingly long time.*
3. **LAUNDERABILITY:** *Rugged and balanced construction plus the exclusive Basco finish preserves the attractive appearance of SIMTEX cloths through repeated washings.*
4. **PROTECTION:** *Patients' gowns and bedding are guarded because tray cloths minimize slipping and spilling.*
5. **THERAPEUTIC VALUE:** *Patients get a pyschological "lift" when you use SIMTEX tray cloths and napkins for room service.*
6. **ECONOMY:** *Modest first cost, long wear and exceptional launderability account for the widely recognized economy of SIMTEX cloths.*

SIMTEX NAPERY in the ever-popular "Ivy" pattern (as illustrated) is available in hospital standard sizes and in yard goods through leading Wholesale Linen Supply Houses from coast to coast.

"Napery of the Nation" Made **RIGHT** in America

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Division of Simmons Company
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FORMERLY ROSEMARY



Henri de Mondeville

(1260-1320)

SUTUREGRAM

NUMBER THIRTEEN IN A SERIES

Sutures – Hemostasis

(1) To ligate vessels in abdominal wall only finest sizes of sutures are needed... #000 or #4-0



(2) Larger vessels in soft pliable tissues can be ligated with fine sutures – but should be transfixed to neighboring tissues to prevent slipping



SUTUREGRAM

NUMBER THIRTEEN (CONTINUED)

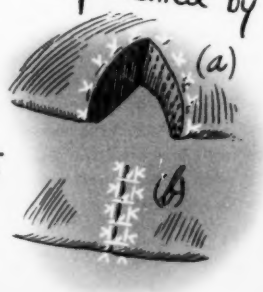
(3) Larger vessels in tough fibrous tissue or imbedded deep in tissues require larger sutures for ligation





(4) Bleeding from vessels which cannot be secured, can be stopped by figure-of-eight suture

(5) Hemorrhage from liver is prevented by placing mattress sutures on both sides of incision (a) then approximating edges with loosely tied sutures (b)



D & G SUTURES

WITH ATRAUMATIC* NEEDLES



an approach to the ideal

Davis & Geck pioneered the development of the Atraumatic needle principle to meet virtually every situation where minimum trauma is essential. In design and construction, D&G Sutures with Atraumatic Needles approach the ideal more closely than any other combination for these reasons:

1. Needles and sutures are practically the *same* diameter and form a smooth, continuous unit.
2. The method of affixing insures positive anchorage to the suture—it cannot pull out... and its strength is unimpaired at the contact point.
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4. All curved needles have a flattened area to prevent turning in the needle holder.
5. Each Atraumatic suture-needle combination has been developed in collaboration with recognized authorities and represents the consensus of professional opinion in its particular field.

THE D&G ATRAUMATIC SUTURE-NEEDLE LINE is the most comprehensive line of its type available.

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DAVIS & GECK, INC.
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"This One Thing We Do"

HENRI DE MONDEVILLE (1260-1320) – Body surgeon to Philip the Fair of France, Henri de Mondeville was a shrewd and original thinker and a vigorous critic of many contemporary orthodox views. For example, he advised that all wounds should be washed and left alone, "since wounds dry much better before suppuration than after it." He urged his students and his fellow surgeons to avoid suture trauma and interruptions in operative procedure by using grooved needles, threaded, and arranged in order prior to operating.



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One FREEZ-A-BAG *cabinet holds from 36 to 49 assorted size bags at one time. Bags easily conform to body contours, covering feverish areas more completely. You have a cold pack service which is more effective therapeutically and more comfortable for your patients.*

Yes, the nurses in any hospital using FREEZ-A-BAGS will tell you —patients get a finer impression of your service when ice caps are replaced with soft and pliant FREEZ-A-BAGS. The glycerine-filled bags freeze to a semi-solid colder than ice—11°F.

Cost studies made of the service in operation prove that it pays for itself in 26 months. FREEZ-A-BAG eliminates the manufacture, purchase, storing, hauling and cracking of ice. It saves the cost of expensive ice caps—the hours wasted by nurses preparing ice, filling and emptying caps.

Ask your AMERICAN Representative for detailed information, or write direct.

PLAN WITH AMERICAN
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. . . You'll want to eliminate outmoded technics and equipment with

POUR-O-VAC SEALS

the modern, reusable hermetic closure for sealing, storing, handling and conserving surgical fluids.



THESE FACTS ARE CONVINCING . . .

Pour-o-vac Seals eliminate the possibility of sterile water contamination caused by intake of bacteria-laden dust . . . avoids contamination by unfiltered air.

They serve a secondary function of providing a dustproof seal for remaining fluid when only the partial contents of a container are used. Of importance, they are interchangeable with all Fenwal 3000, 2000, 1000 and 500 ml. containers.

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ALSO INVESTIGATE—Fenwal Automatic Washing Units, capable of accommodating and thoroughly cleansing 4 containers in 30 seconds.

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ORDER TODAY or write immediately for further information

Fenwal

MACALASTER BICKNELL COMPANY

243 Broadway **Cambridge, Massachusetts**

Stainless Steel makes things so much easier around the hospital!



Nurses are partial to Stainless





To a busy nursing staff, every minute that can be saved in keeping equipment clean and sterile means greater opportunity to add to the care and comfort of the hospital's patients.

Because it cleans so easily, Stainless Steel equipment makes it possible to save precious minutes, yet maintain the highest standards of cleanliness and sanitation. It's the perfect metal for use in the operating room, the sterilizing room, the kitchen—wherever there's need for its shining spotlessness.

Administrative staffs are partial to Stainless, too, for it resists corrosion almost indefinitely under the most trying conditions of heat, steam and moisture. It's so strong and tough that it is almost impossible to wear it out in spite of hard knocks and severe service.

When you're considering new equipment, think in terms of Stainless Steel. And if you write "U·S·S Stainless preferred" on your order, you'll get a perfected, time-tested Stainless that is unsurpassed in quality and performance.

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UNITED STATES STEEL

"Successful operation"

Economical INTERIORS


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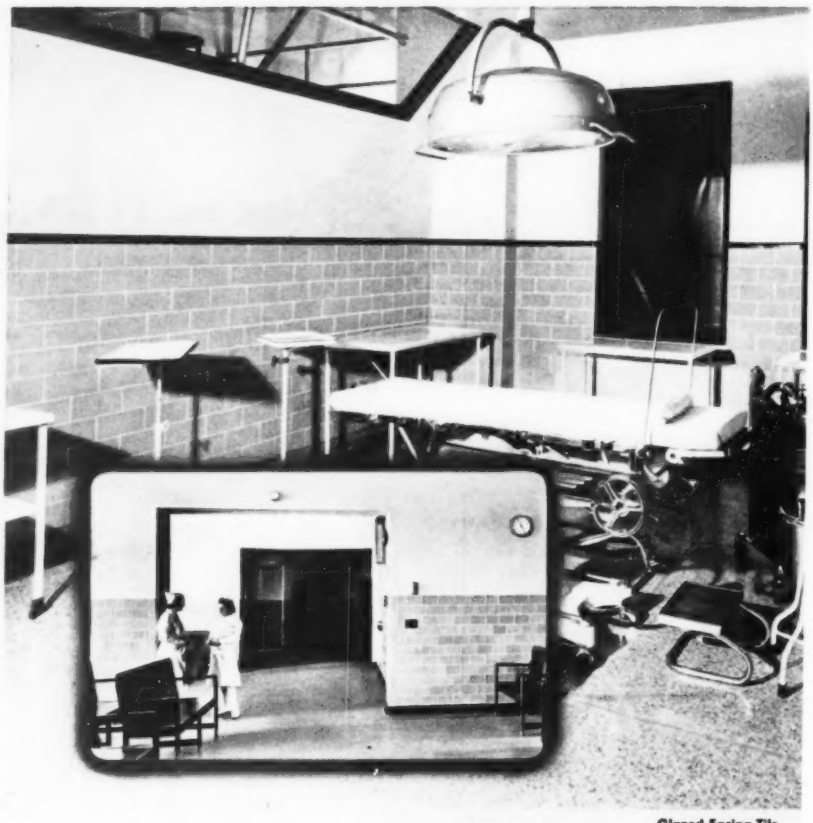

HOSPITALS



DAIRY PRODUCTS


PACKING PLANTS


INDUSTRIAL PLANTS


Glazed Facing Tile


DRUGS & CHEMICALS


FOOD PROCESSING


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RENTAL HOUSING


PUBLIC BUILDINGS

for budget-strain in hospitals

of *Facing tile*

Tough, durable, easy-to-clean Facing Tile can help you make an anemic hospital budget positively *radiant* with health!

Being radiant itself, glazed Facing Tile creates a cheerful "get well" atmosphere for patients, too!

In short—Facing Tile means "successful operation" in hospitals.

You can use Structural Clay Facing Tile *throughout* the hospital—in corridors, wards, kitchens, laboratories, operating rooms. It will stand up to years of hard wear and never crack, scratch or decay, never require redecorating!

Expose Facing Tile to dirt, grease, steam, or almost any acid. It will wash down *clean* and quickly, because it's *impervious*—even to bacteria!

With Facing Tile you get the additional economy of a permanent finish and a permanent wall, *in one material!* It's strong, firesafe and modular sized for fast building. Many light-reflecting colors are available, both glazed and unglazed.

When you plan new hospital interiors, remember that economical Facing Tile helps keep your budget healthy. For complete information write the Institute, Desk MH-6, or contact any member.

SEND FOR *NEW* FACING TILE CATALOG. Have this valuable, file-sized book on hand for ready reference. It will answer many questions about the use of Facing Tile. Simply write Institute, Desk MH-6, on your letterhead.

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THE GROWING HOSPITAL needs plenty of pure, freshly-distilled water to meet its expanding requirements. Whether its a tiny ½ gallon per hour laboratory still, or a 30 gallon per hour steam model, such as the one shown at the right, Barnstead makes a model which will exactly fit your needs. These are models for operation by steam, gas, electricity, and kerosene, in a wide range of capacities. Our special catalog of Hospital Stills gives complete data on stills, full automatic controls, storage tanks, recessed equipment, etc. Write for your copy today.

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STILL & STERILIZER CO.

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Why the Barnstead Type "Q" Still is the Hospital Favorite . . .



DOCTORS LIKE IT *because*

. . . they know it delivers the highest purity water possible with a single effect still, safe even for parenteral solutions and blood plasma work.

NURSES LIKE IT *because*

. . . they know they can rely upon the constant unvarying quality of the distillate. When operated with reasonable care, there is never the slightest variation.

TECHNICIANS LIKE IT *because*

. . . of its trouble-free operation. Barnstead Stills are automatic in operation — it is merely necessary to turn on the water supply and the heat.

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. . . its scientifically correct design reduces the need for cleaning. Barnstead Stills operate for long periods without requiring cleaning — even in hard-water areas.

Your Surgeons Thank You For Almost Barehand Freedom When You

Specify **Rollpruf**

PIONEER

Surgical Gloves

They know that Rollpruf's sheerness gives them finger-tip sensitivity, that they always fit smooth and snug. That's why more and more surgeons are asking their surgical buyers to specify Rollprufs.

There are other reasons, too:

- **Rollpruf's flat-banded cuffs won't roll down and annoy during surgery.**
- **Banded wrists also reduce tearing—add to glove life.**
- **Rollprufs are processed to stand extra sterilizings.**
- **Made of DuPont neoprene (in the new hospital green color for easy sorting) or pure latex.**
- **Neoprene Rollprufs are free of the dermatitis-inducing allergen sometimes found in natural rubber.**

Adopted by many hospitals everywhere, Rollprufs are more for your money. Specify Rollprufs — insist on them from your supplier — or write us. *The Pioneer Rubber Company, 750 Tiffin Road, Willard, Ohio.*



Pioneer Skin-Finish Rollprufs — made of latex rubber, new skin-soft texture. Non-slip finish on fingers adds remarkable new sureness to surgeon's touch. Flat-banded cuffs — no roll down.



Pioneer Autopsy Gloves—durable comfortable lightweight neoprene gloves. Non-slip finish for greater dexterity. Free of dermatitis-inducing allergen sometimes found in natural rubber.



See our complete Surgical Glove Catalog in Hospital Purchasing File.

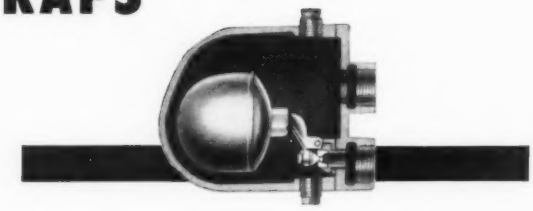
PIONEER *Surgical Gloves*

★ The Result of Over 30 Years of Quality Glove Making ★

From **UNIT HEATERS**



To **FLOAT TRAPS**



DUNHAM HEATING PRODUCTS *pay off in* PERFORMANCE

Increase operating efficiency . . . cut your costs

One outstanding quality of all Dunham heating products . . . a quality upon which Dunham customers unanimously agree . . . is their superior construction.

For example, the attractive casings of Dunham Type V Unit Heaters have rounded corners and folded edges for extra eye-appeal. Their simplicity of design and sturdy steel construction give them maximum strength and rigidity. A cushion-bonded motor, operating at moderate speed, insures quiet performance. While outlet air temperatures are carefully balanced with air velocities to provide healthful comfort at minimum cost.

This skill in engineering and manufacture means better performance on the job . . . longer trouble-free service . . . more heat at less cost . . . greater tenant satisfaction.

Products like these made the Dunham Differential System famous. It is upon such precision-built and job-proved products that the Dunham Vari-Vac* heating system is based—and it is their dependable operation that has made possible the sensational fuel savings for which this system is nationally famous.

So, regardless of your heating need—whether it's for a single trap or all the elements needed to heat your entire building, or group of buildings—it will pay you well to look first at the Dunham line.

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Write today for your free copy of Bulletin 634B. Contains complete information on Dunham steam specialties, unit heaters, pumps, cabinet and baseboard convectors.



C. A. Dunham Co., 400 W. Madison St., Chicago 6, Ill.

*Variable vacuum

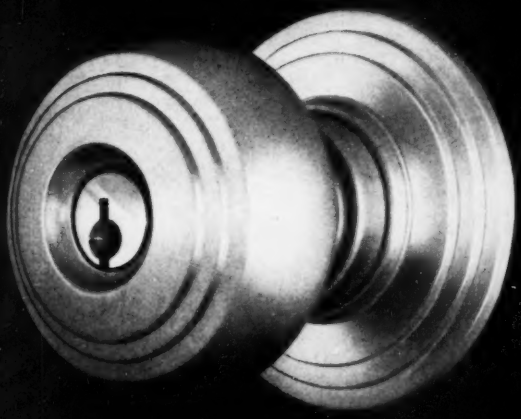
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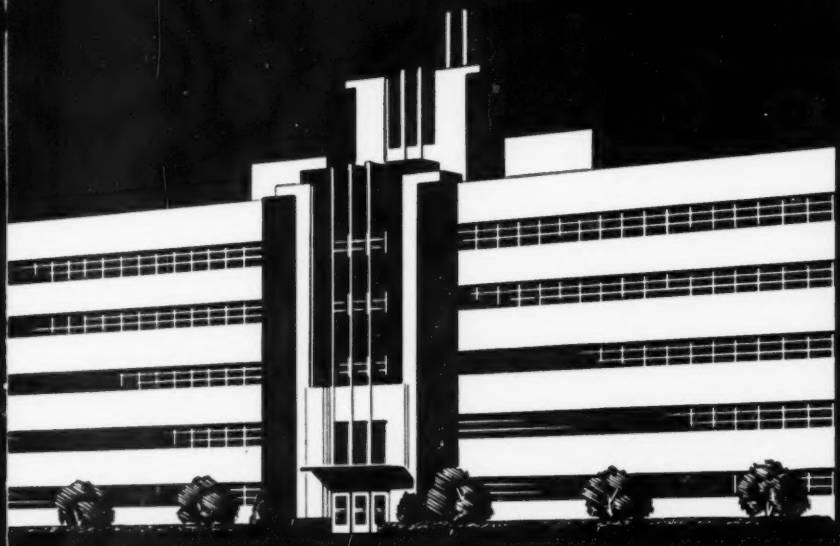
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SCHLAGE

Novo Design

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SAN FRANCISCO · NEW YORK

Kitchen Layout by John J. McDonald,
Reg. Prof. Engr., Boston

Sancta Maria Hospital, Cambridge, Massachusetts.
Sister Mary Honorata, R.N., B.S., Administrator

STREAMLINED *GAS* KITCHEN PROMOTES VOLUME COOKING EFFICIENCY





Stainless Steel Baking Equipment including Gas Oven.



Stainless Steel Cooking Unit consisting of Gas Ranges, Griddle, Fryers, and Broilizer

KITCHEN PLANNING paid off in efficient food service and operating economy when Sancta Maria Hospital adopted modern Gas-fired Cooking and Baking Equipment for its stainless steel food preparation system. The streamlined arrangement and flexible fuel are best described by Sister Mary Scholastica, Dietitian, **"GAS involves the minimum amount of effort on the part of our personnel to maintain the high standards of cleanliness, economy, and dependability required in everyday operation with our stainless steel kitchen."**

To demonstrate the flexibility of modern Gas Equipment, it's only necessary to look over the list of units—

Two Vulcan Ranges • One Vulcan Frytop
Two Vulcan Fryers • One Blodgett Oven
One McDonald Broilizer

Although serving about 9000 meals per month for its present patients and staff the streamlined kitchen is sufficiently flexible to care for greater food service requirements. With modern Gas Equipment, the automatic controllability and speed of GAS are perfectly suited to heavy food service demands.

For every volume cooking requirement you need GAS—its economy, speed, flexibility, automatic controllability. Be sure to ask your Gas Company Representative for the latest information on modern Gas Equipment.

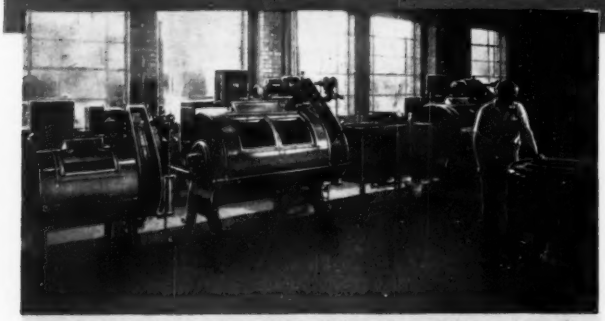
MORE AND MORE...
THE TREND IS TO GAS
FOR ALL COMMERCIAL COOKING



Sancta Maria Hospital's streamlined kitchen

AMERICAN GAS ASSOCIATION 420 LEXINGTON AVENUE, NEW YORK 17, N.Y.

American Modernized the Laundry Department



In bright new laundry building, three NORWOOD CASCADE Washers and 30" Extractor launder all linens and uniforms sterile-clean on short schedule.

at 150-bed St. Patrick's Hospital, Missoula, Montana



Linens are beautifully ironed, quickly and economically, on this 6-Roll STREAMLINE Flatwork Ironer.

Problem . . . Operating costs of old, obsolete laundry were high. Equipment was unable to launder sufficient linens and meet quality standards of the hospital.

Solution . . . Our Laundry Advisor was called in. He analyzed hospital's laundering requirements, submitted recommendations and a suggested equipment layout. Hospital then installed modern, cost-reducing equipment in new laundry building.

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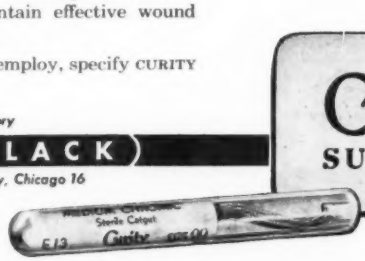
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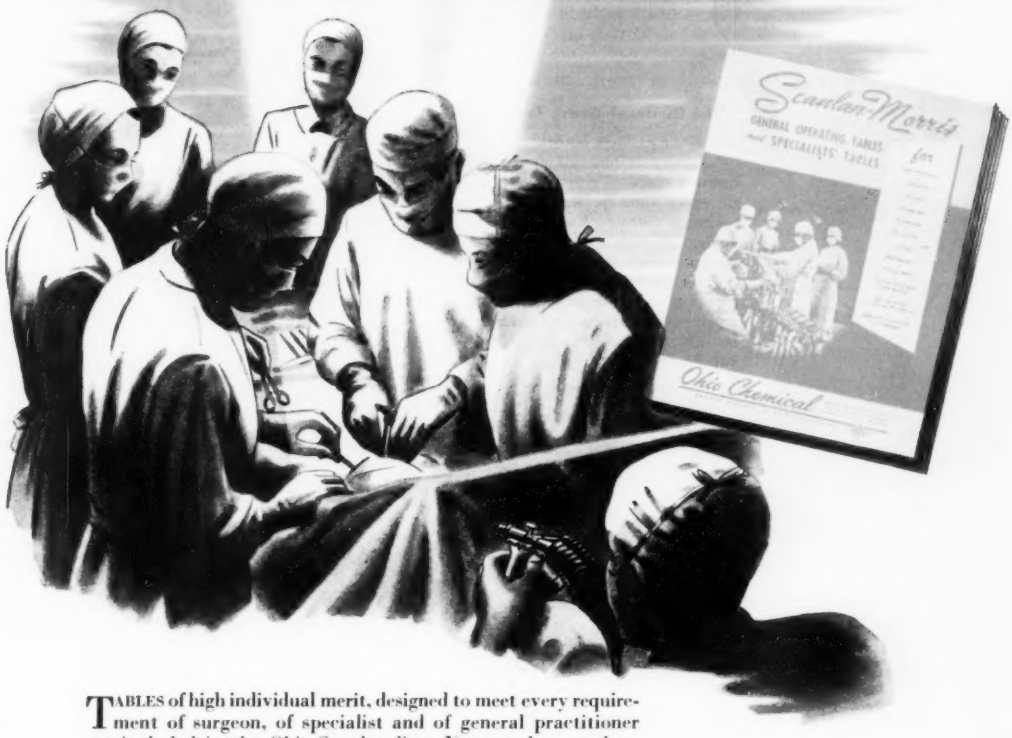
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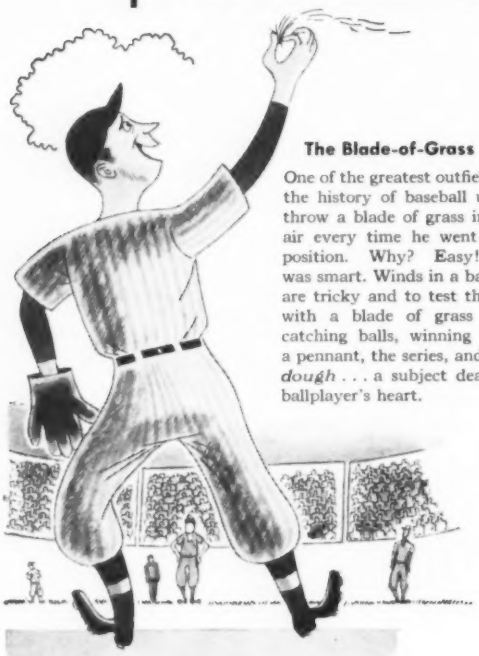
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One of the greatest outfielders in the history of baseball used to throw a blade of grass into the air every time he went to his position. Why? Easy! . . . he was smart. Winds in a ball park are tricky and to test the wind with a blade of grass meant catching balls, winning games, a pennant, the series, and *more dough* . . . a subject dear to a ballplayer's heart.



The Who's-Listening-To-What Test

"How's your Hooper" is the popular greeting with radio entertainers. That is, it's popular if the Hooper is good . . . for the Hooper is a test of a program's popularity determined by thousands of phone calls throughout the day asking people in homes "What program are you listening to?" Naturally, a good Hooper pays off.



The Down-To-Earth Test

Warning! Before you buy that little farm . . . that place to get away from it all . . . be sure to have the soil thoroughly tested. It will save you plenty of headaches.

The How-Many-Feet-in-a-Gallon Test

Here's the tip-off that pays off on paints. When considering paints for the interior of a building, *forget about the cost per gallon.* It doesn't mean a thing. The real factors to consider are the number of square feet of proper coverage you get per gallon and . . . because labor represents 80% of your total cost . . . *the time involved for painting.*

See for yourself. Compare a gallon of any paint you want with a gallon of Barreled Sunlight. Thin them both according to directions. Put them on a wall. Check the number of square feet each covers. Check the length of painting time for each. Note the difference in appearance after drying. You'll be thoroughly convinced that Barreled Sunlight . . . even though it costs more per gallon . . . will give you a better-looking, long-lasting paint job *for less money* than any other paint.

It will pay you to talk with your nearest Barreled Sunlight representative. Write, and he'll call.

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Small Hospital Questions

Good Paint and Bad

Question: How can I distinguish between good and cheap flat wall paints?—R.W.H., Ill.

ANSWER: Several manufacturers point out that good flat wall paint should have approximately the following composition:

	Original Good Flat	*"Chiselers" Flat*
Volume of hiding pigment..	46%	40%
Volume of inert pigment..	14%	25%
Volume of binder.....	40%	35%
	100%	100%

In other words, you should be wary of any paint that is offered as a bargain. It is best to deal with known, reputable concerns and to be sure that no one has cheapened the paint before it is delivered to you.

Handle With Care

Question: We have been advised that disposal of burned-out fluorescent light tubes should be conducted with great care to avoid injury. What is the danger involved?—H.H.,

ANSWER: While fluorescent tubes in use are not dangerous and there should be no prejudice against their installation, hazards do exist when the tubes are broken.

That warning was issued recently by John V. Grimaldi, industrial safety director of the accident prevention department, Association of Casualty and Surety Companies.

The tubes are coated on the inside with phosphor, which often contains a salt of the metal beryllium. When the glass is shattered, cuts by fragments coated with beryllium salt may result in granuloma, a benign tumor of the skin. Inhaling the dust from broken tubes may cause lung trouble.

As a practical safety measure, Mr. Grimaldi suggested that a worn-out tube, before being discarded, should be placed in the carton containing the replacement. Care should be taken that the box does not protrude from the trash can or other receptacle in such a way as to be smashed easily.

The New York City health authorities have adopted this list of precautions for disposing of burned-out lamps:

Keep discarded tubes away from children. Never break tubes or place them in incinerators. Deliver them directly to refuse collection trucks.

Should a tube be broken, sweep up the fragments and wrap them in heavy paper. Never handle broken fragments without gloves. If cut by a broken tube, consult a doctor immediately.

A safety pamphlet issued by the Association of Casualty and Surety Companies lists precautions that should be taken by persons who must destroy the lamps in quantity.

1. Goggles or other safeguards for the eyes should be worn to provide the greatest protection possible from flying glass.
2. Sturdy gloves should be worn.
3. Small numbers of lamps should be broken out of doors, preferably in a waste container or in a waste disposal area.
4. Operators should stand with the wind at their backs so that toxic dust and vapors are blown away from them. Each operator, if possible, also should be equipped with an approved respirator.
5. Lamps also may be broken under water in a barrel or trough, so that dust does not enter the air and danger of flying glass is eliminated.
6. When large numbers of lamps are to be smashed indoors, a ventilated hood should be used to draw dust and vapors out of the building. An isolated room should be chosen for the location of this hood.
7. Final disposal of the broken lamps should be made so that the public is protected from dangerous exposure. Lamps should be buried in a dump or deposited under water being used for disposal of industrial wastes, so that the dust cannot be disturbed and distributed throughout the community.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Plaster Failures Costly

Question: How can we reduce the costly repair of plaster walls where there have been cases of plaster failure?—H.N., Okla.

ANSWER: Manufacturers are now producing a lime that helps to eliminate costly plaster failures, the National Bureau of Standards announced recently.

Research at the Bureau of Standards has revealed that plaster failure of the blister type, costing many millions of dollars a year, is caused by the expansion of one of the components of the lime used in preparing the white coat of plaster.

If failure is to be avoided in plasters, no disruptive change in volume can occur once setting has taken place. The Bureau of Standards discovered that volume expansion, however, does occur, resulting in bulging, blistering and buckling in the white coat. This expansion results from the gradual combination of water with one component (unhydrated magnesia) of the lime used in preparation of the white coat. Such water absorption takes place slowly, and most failures occur several years after the white coat is applied.

Following this discovery, federal experts undertook research to develop a method for treating lime so that such expansion would become impossible. The method involves the use of a large autoclave in which heat and moisture are used to effect a chemical bonding of water with the components of the lime. The resulting compound is stable with respect to water.

The results pointed the way to commercial application of the method and manufacturers are now producing a dolomitic lime, one with the magnesia so well hydrated that harmful expansion does not take place.—E. U. CONDON, *National Bureau of Standards, Washington, D.C.*

"Talc is a Dangerous Agent in its present use as a Surgical Glove Lubricant"[1]

SAFE SUBSTITUTE NOW AVAILABLE AT COST OF ONLY 2¢ PER OPERATION

Postoperative adhesions caused by glove powder have long been a serious concern of surgeons and operating room assistants.

All published studies agree that talc as a glove lubricant is unsafe. Animal experiments have shown the dangerous complications that follow talc implantation.

* * *

EFFECTS IN TISSUE

Talc consists chiefly of magnesium silicate. It causes granulomatous reactions in tissue, resulting in intra-abdominal adhesions, persistent sinus formation, or nodules in the wound.

* * *

"Implantation of glove powder may occur from unwashed gloves, perforations in gloves, spill on to sponges, instruments, and suture material, and by the air-borne route."[1]

* * *

SERIOUS COMPLICATIONS

"The frequency of such contamination is attested by the increasing number of case reports of serious complications due to talc. Animal experiments show that the granulomatous reaction can be regularly produced in the peritoneum, pleura, pericardium, muscle, joint, nerve and tendon."[1]

FOREIGN BODY REACTION

German[2,3] found intra-abdominal granulomata which he proved came from foreign body reaction to talc in 40 out of 50 unselected patients subjected to a second laparotomy.

* * *

Seelig[4,5] repeatedly demonstrated the danger of talc in mice, which are notably resistant to the production of adhesions, by injecting 2cc. of a 5% saline suspension of the powder intraperitoneally, and has stated that "the average surgeon cannot possibly perform this experiment and ever afterward face talcum powder with equanimity."

* * *

REPLACEMENT

As a replacement for talc, a wholly safe and efficient dusting powder is now available. This new powder, called Bio-Sorb, is a mixture of amylose and amylopectin, derived from corn starch, with a small amount of magnesium oxide added. It is treated physically and chemically to assure good lubrication after sterilizing.

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Bio-Sorb is compatible with body tissues and is rapidly absorbed. It does not injure rubber gloves. It fits regular O.R. technics. Costs less than 2 cents per operation. Bio-Sorb has been used over two years in several hundred hospitals. Complete literature mailed on request.

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SAFETY CONFIRMED

The findings of Lee and Lehman[6] that Bio-Sorb is safe have been confirmed by Lindenmuth[7] and MacQuiddy.[8] Postlethwait et al[1] concluded that "talc is a dangerous agent in its present use as a surgical glove lubricant," and stated that "a modified starch powder (Bio-Sorb) which is absorbed with little or no reaction is again suggested as a satisfactory substitute for talc."

* * *

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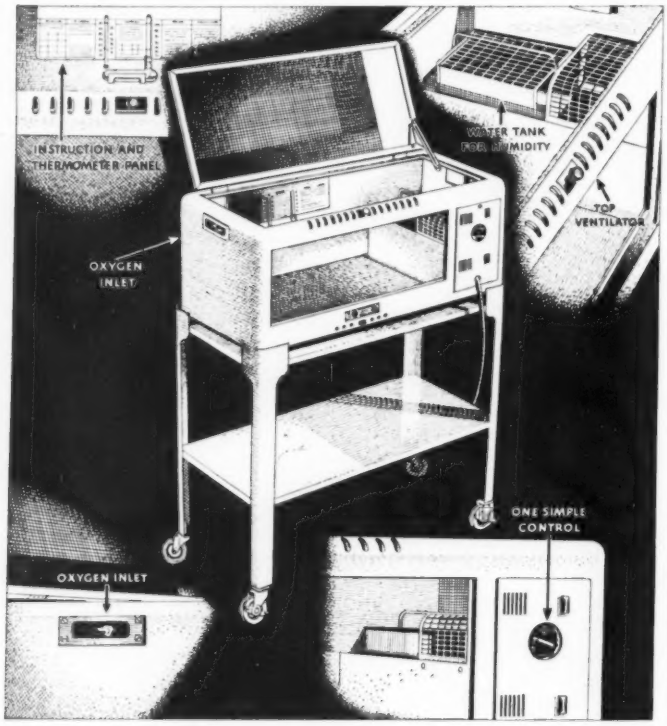
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Looking Forward

Balanced View

STARTING in this issue, The MODERN HOSPITAL is presenting a series of articles about hospitals and socialized medicine, based on a study of the operation of hospitals under the National Health Service which became effective in Great Britain last year. To gather material for these articles, one of our editors made a trip to England, where he visited a number of hospitals and talked to administrators, doctors, trustees, nurses, government officials and others about their problems today.

The possibility that some form of socialized medicine may come in the United States has been with us constantly since the war ended; it is important for administrators here to know what happens to hospitals in a nationalized health service system. Hospital trustees and auxiliary members, too, should know what the experience of British hospitals has been; as the Volunteer Forum on page 88 of this issue points out, these groups can have no more important function than to help preserve our medical and hospital freedom.

Readers who expect that the articles on British hospitals will condemn the whole British health service, however, will be as disappointed as those who are looking for arguments to support the socialist view. Our reporter has described what he saw and heard in England without bias on either side. Moreover, during his visit he deliberately sought out authorities of all political opinions and social philosophies, with the end in view of giving our readers a balanced evaluation of the facts that have emerged in the operation of the National Health Service. Journals which have presented only one side of the British experience, in our opinion, have underrated the intelligence and integrity of their readers.

The MODERN HOSPITAL is opposed to the socialization of medicine and the nationalization of hospitals in the United States. In contrast with many of those with whom we share this position, however, we believe that the proponents of socialized medicine are, on the whole, as sincere and beneficent in purpose as its opponents. We believe the interests of the nation will be served best by presenting both sides of this and other issues as fairly and dispassionately as possible and letting an informed public make its choice. To this principle, which is at the heart of the democratic process, we are more devoted than to any system of medical care.

Counsel, Spare That Ax!

THE ascendancy of the management counsel or administrative consultant in recent years has been a notable development in the hospital world as well as in business, where management engineering firms have proliferated and prospered, turning out reports by the mile and, on the whole, probably saving their clients more than they cost them. At a time when hospital boards generally are becoming aware of the unhappy fact that they are spending more than they take in and things are getting worse instead of better, the consultant's appeal is understandably strong—and in many cases fully justified.

In all this, however, there is a hazard. The fact is that in every hospital, as in every business, there is enough of illogic and inefficiency to permit a report that will condemn the management and make the consultant out a very shrewd article indeed. The administration of human affairs is never completely tidy, and the unscrupulous consultant can make a career out of exposing and exaggerating its inevitable untidiness. Reputable and moral counsel, on the other hand, will choose in many instances to pass over the occasional aberrations of an administration whose performance is generally good,

even when this policy may reduce the high shine on counsel itself.

The interests of the hospital or business are usually served best by aiding the existing management to do a better job and avoiding the upheaval that comes with change. Wise counsel, like wise ownership, recognizes that except in extreme cases there is little to be gained by replacing one administrator with another. Usually, this means trading one kind of untidiness for another and adding the heavy cost of turnover; all administrators are human beings.

Without exception, consultants bidding for a contract will insist that they can serve themselves only by acting in the best interests of the client, but this is only partially true. There are times in every situation when the immediate interest of the counsel and the ultimate interest of the client are in conflict. That is why the consultant's moral qualifications are even more important than his professional knowledge and skill, and why the selection of counsel is one of the hardest tasks the hospital trustee has to face.

Get Busy Now

THE fact that the Hill Bill for federal aid to indigents through existing voluntary agencies will die a natural death in the present Congress does not in any way diminish the achievement of those who helped to prepare and introduce it. The American Hospital Association, especially, deserves credit for the vigorous and intelligent leadership it provided in sponsoring this wholesome legislative proposal. The American Medical Association, too, merits thanks from the nation's hospitals for the approving pat on the back it gave the Hill Bill—a particularly impressive gesture in view of the A.M.A.'s well known policy of restraining its enthusiasm for legislation bearing on the practice of medicine.

Unquestionably, the Hill Bill will be introduced again next year; what happens to it then may depend to a large extent on the effectiveness with which its supporters have organized their activities in the meantime. It is to be hoped that the hospital and medical associations and others interested in the passage of the bill will not confine their efforts to picture-poster publicity and pontifical utterances about the American way of life, or to the kind of high-pressure organization work that gets hundreds of letters and postcards sent to Congress, all carrying the same message written in the same slick language. However well intentioned, these technics have become so commonplace today that they shriek of special interest and usually arouse as much suspicion as support for the causes they seek to advance.

There is time to do the job right, and individual hospital people can help tremendously to get it done. Every administrator should familiarize himself with the proposed legislation and should make it a personal obligation to see that trustees, doctors, auxiliary members and others connected with his hospital also know what the bill seeks to accomplish and why it is desirable. Hospital trustees, especially, through their business and other organizational connections are in a favorable position to inform many different elements of the community.

In discussing the bill with others, however, businessmen and doctors must be careful to avoid the kind of approach that would give their interest a class flavor and antagonize labor and farm groups. The canned speech prepared by some remote public relations Johnny invariably gives itself away and meets with indifference or opposition. What is needed is a strong nucleus of hospital people who understand the issues and are keen to spread their understanding throughout the community. If administrators and trustees get busy now, a fair share of the letters that go to Congress about the Hill Bill next year will be written in pencil. That kind of mail gets read.

Every Dollar Counts

A SPEAKER at one of the recent hospital conventions made much of the fact that the nation's voluntary hospitals are going in the hole at the rate of $200 million a year. Nobody asked him to prove his figures, but the chances are that it would be as hard to prove him wrong as right. In either case, there is no doubt that hospitals are accumulating deficits at an alarming rate, whatever the total achieved every twelve months.

There is no doubt, either, that a sizable amount of the deficit—again, nobody knows exactly how much—is accountable as an involuntary subsidy to various government agencies which are responsible for indigent patients but don't pay the full cost of their care. Wherever such patients are cared for at contract rates that are under cost, either the difference is reflected directly as a hospital deficit or everybody else who gets sick and goes to the hospital is paying a compulsory but hidden tax. Private and semiprivate patients pay a little more for their rooms and services than they should pay as the hospital struggles to keep revenue within hailing distance of expense. The rate paid to the hospital by Blue Cross must carry its share of the burden, and this means that the rate paid to Blue Cross by its subscribers is also loaded with an expense which, theoretically, is an obligation of local government.

Plainly, the whole community, and not just the hospital, should be interested in correcting this absurdity of hospital finance. Experience in a number of communities has demonstrated that when the facts are known, improvement is likely to result; rate-making public officials are always responsive to public pressure. Hospital administrators and trustees who permit this condition to continue unchecked are thus contributing to a financial burden which could conceivably wreck the voluntary system. Blue Cross directors, whose interest in the problem is direct and material, should join forces with their hospitals to get indigent rates up where they belong.

HOSPITALS UNDER SOCIALIZED MEDICINE

WHAT HAPPENS TO HOSPITALS under a national health service? To get the answers to this question, which has vital significance for American hospital administrators today, The MODERN HOSPITAL sent its managing editor to England to study the effects on hospitals there of the National Health Service which became effective eleven months ago. The editor spent three weeks in England, visiting hospitals of all sizes and types in London and the provinces and interviewing administrators, board members, doctors, nurses, employes and patients—hundreds of people all told. He also discussed the health service and its attendant problems with a number of interested business executives, government officials, economists and journalists in England.

The results of these observations and interviews are reported in a series of articles of which this is the first. In presenting these articles the author asks MODERN HOSPITAL readers to remember that the success or failure of the British plan must be viewed against the background of British hospital and medical standards rather than our own. "Any conclusion one may reach about the British program does not necessarily apply to the United States," he warns. "Differences between medical and hospital systems in the two countries have been broad enough so that what is right for them might be wrong for us."

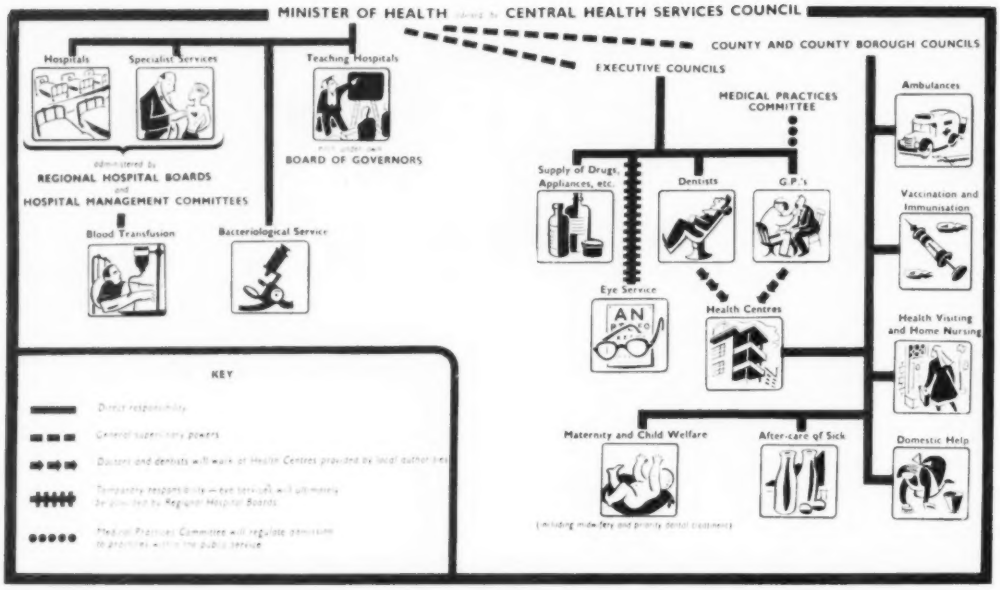
THE EDITORS

IF YOU'VE *got to have any kind of national health service in America, take it on a little bit at a time instead of all at once, the way we did.*

That is heartfelt advice to their American colleagues from British hospital people, who are hip-deep in Health Ministry regulations today. The impact of Britain's Health Service Act, which became effective last July, has altered the lives of hospital administrators there in a way that can probably be understood best by Americans who were in the medical administrative service of the armed forces; instead of being chief executive of an independent enterprise, the administrator now heads a small unit in a vast system. Instead of making decisions himself, he acts as a way-station in the flow of paper toward the decision-making body, which may be a district, regional or national board, depending on the amount of money and number of people involved in the particular decision.

R. M. CUNNINGHAM JR.

Of course, British administrators don't like this aspect of their program any more than Americans would. At a recent national conference of administrators at which speakers from the floor were asked to identify themselves by name and position, one administrator rose and gave his name, then added wryly, "Not a civil servant



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—yet." Similar remarks by speakers and discussants throughout the meeting indicated that Britons are chafing, if not burning, under their burden of government paper.

At the same time, it should be noted, most hospital people acknowledge that something like the Health Service Act was needed to fill the gap that yawned menacingly between revenue and expense in Great Britain's voluntary hospitals. Many hospital executives, in fact, are convinced that the Act is accomplishing its main objectives as well as could be expected, and that the administrative difficulties are only "teething troubles" which will be outgrown in time—a benign view that few British doctors would agree with and many would apoplectically deny. Whole-hog supporters of the plan warn against the gradual, or step-by-step, approach on the ground that deferred portions of the program would tend to get delayed indefinitely as officials wrestled with comparatively unimportant details of the early phases. "It's like a young couple planning to get married," one hospital board member explained. "If they postpone the wedding until every contingent detail is worked out—job, money, a flat, furniture—they're likely to keep on putting it off until it's too late. On the other hand, if they go ahead and get married right away, without waiting for conditions to be perfect, their troubles are usually ironed out as they go along."

To strain the analogy a little further, the main difference between England and the United States is that in their case the desirability of the wedding was no longer a matter for serious argument, while in ours the bride's and groom's families are glaring at each other from opposite theoretical positions. In America we are still heatedly disputing the *whether;* in England the argument is largely confined to the less controversial *how.* The extent to which this is true is illustrated in a political poster that was displayed recently around London. "Conservatives fought for and will keep the Health Services," this said. As it is operating today, the National Health Service Act is not greatly different from the program that was first proposed by Britain's coalition government twelve years ago.

The purposes of the Act are briefly but unmistakably set forth in its opening paragraph: "It shall be the duty of the Minister of Health to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness." To accomplish this commendable aim, the Minister was authorized to set up three parallel services—the general medical and dental service, the local health authority service, and the hospital and specialist service. Ministry estimates for the coming twelve months indicate that the hospital and specialist service represents approximately 60 per cent of the total cost of the program.

Conservatives here who are alarmed because, as they see it, the United States has started a slow slide toward socialism may be comforted by the fact that it has taken British socialists nearly 40 years to get where they are today. If compulsory health insurance is socialized medicine, Britain has had it since 1912, when a health insurance act was passed by Lloyd George's liberal government, the ideological grandfather of today's ruling party in Parliament. The insurance, however, was not as comprehensive as that which is now proposed for the United States. Participation was limited to workers earning less than a stipulated amount, roughly equivalent to $1700 a year, and only the workers themselves were covered; wives and

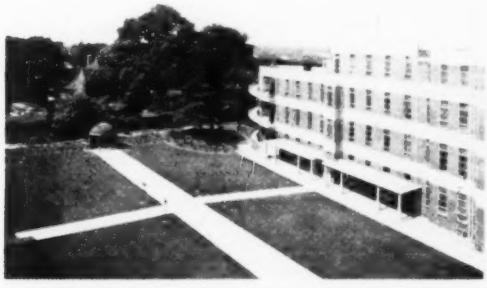
children paid their own way or went without.

The new National Health Service, in contrast, covers everybody—including Swedish schoolteachers on holiday and visiting reporters from the United States. Moreover, Ministry officials are at pains to explain that the health service is not an insurance scheme. Rather, "It is a charge on the national income in the same way as the armed forces and other necessities." Obviously, such a service requires full government control of the hospital system, an eventuality which may be avoided under compulsory health insurance. When the insurance is so comprehensive that the government becomes the principal, if not the sole, purchaser of hospital care, however, as it would be under the system proposed here by President Truman and others, it would seem only prudent for the government to outline the conditions under which hospital care will be bought and delivered. What is happening to hospitals in England today is thus in many ways a foretaste of what would happen to U.S. hospitals if a comprehensive national health plan were to be undertaken.

What is happening to British hospitals is either a bad thing with certain good features or a good thing with certain bad features, depending on the experience and social philosophy of the individual observer. The fact is that the British hospital program in operation combines some of the worst nightmares and some of the fondest dreams of American hospital administrators. To see how this is true, it is necessary to understand how the system works. When the Health Service Act became effective (on July 5, 1948, which is invariably referred to as "The Appointed Day," in tones that range from respectful awe to smoldering resentment), the government seized the nation's hospitals, root and branch. With a few exceptions, notably some three dozen hospitals designated as teaching centers and set aside for special treatment, and a scattered 270 hospitals which the Ministry has decided it doesn't want for one reason or another, the entire hospital system (3200 hospitals) was placed under the control of fourteen regional boards, made up for the most part of former hospital governors, or trustees, doctors, labor representatives and interested laymen. These boards have delegated authority in turn to local hospital management committees, similarly constituted, which have absolute rule over groups of three or four to as many as 20 hospitals, totaling from 400 or 500 to several thousand beds. The management committee has a paid secretary, usually the former administrator of the largest or most influential hospital in the group, and a paid staff whose size varies with the size of the group. However, the Ministry likes to point out that nearly all committee and board members serve without pay and are thus preserving the voluntary spirit in hospital care. Moreover, the official view of the management committee system is that it assures decentralized control and thus guards against the dreaded development of hospital care by remote bureaucracy.

As the same city presents entirely different aspects to a man walking its streets and a flier passing overhead at 10,000 feet, the spirit and control of a hospital may look altogether different to the local executive and the civil servant. Obviously, what is "decentralization" in the eyes of Whitehall may be bureaucracy of the most damnable sort to an administrator who must now look to a committee secretary 20 miles away for authority to buy a bedpan, and the Minister's bright talk about the voluntary spirit is likely to strike a sour note in the community whose erstwhile hospital board now has a lone representative, say, on the local management committee.

The big idea of the group management plan, of course, is to achieve what American hospital theorists are always talking about—integration of service. The degree to which integration is actually being achieved varies widely from group to group, but even those who take a dim view of the Act acknowledge that some duplication of function will probably be eliminated. At its best, the group management plan is moving steadily toward the kind of regional hospital system envisioned by our own Commission on Hospital Care and charted several years ago by the U.S. Public Health Service. With the one big obstacle of local autonomy removed, the development of an integrated service is entirely a matter of the strength and will of the committee secretary. Already tightly managed committees are doing some group purchasing and long-term contract buying. Through food service, nursing, stores and other functional subcommittees, these groups are working toward uniform standards of service at the levels achieved in the best hospitals. Pathology and radiology services have been established on a group basis in a few areas. Some are even planning and talking about the ultimate integration



The Kent and Sussex Hospital at Tunbridge Wells, 50 miles south of London, a 350 bed voluntary institution that the government took over when the National Health Service got under way last July.



St. Thomas's Hospital on the south bank of the Thames in London. The three ward blocks at the left were bombed out during the war and had to be abandoned. The hospital was hit twelve times.



Cottage hospital at Edinbridge, Kent, a former voluntary enterprise that is now part of the hospital management committee system for the whole area.

of all medical services, with pediatrics concentrated in one unit, for example, obstetrics in another, surgery elsewhere, and an inter-group transportation system delivering patients where the best highly specialized care is quickly available. It's a vision that stirs the imagination of hospital people whose beautifully worked out plans for integrated service invariably collide at some point with the provincial pride of small-town bankers and merchants who insist that Snatchville must have "the best little hospital in the whole danged country!"

On the other hand, those who call integration "remote control" and point out gloomily that it is taking decision-making authority farther and farther away from the patient's bedside certainly have a legitimate criticism of the system. Requests for authority to take necessary action may disappear into the complicated machinery of committee operation and get lost there for weeks, administrators and departmental executives complain bitterly. While a certain amount of this kind of talk may be explained away as the inevitable grumbling of executives whose stature has been diminished by the imposition of a higher authority, there can be no question that hospital care suffers when time and distance get between patient and administration. A pathologist reports that his request for an additional technician to keep abreast of the growing volume of examinations was unceremoniously denied by the committee secretary in obedience to a national policy aimed at keeping mounting costs under control. "I can't do justice to my work without more staff," the pathologist said. "I'm doing penny-in-the-slot pathology now, and it's getting worse instead of better under present conditions. Yet the committee says I mustn't have more help because the budget won't permit it. The patients are the ones who will suffer."

Supporters of the scheme admit these handicaps exist but insist that they are the inevitable growing pains of a vast new program and will be rectified as rapidly as the system "sorts out" or "shakes down"—favorite expressions of National Health Service enthusiasts. Harder to evaluate but possibly even more important than such practical problems is the charge that the hospital's spirit of service to the sick and suffering gets diluted somewhere along the route toward integration. There is no doubt that management by committee impersonalizes hospital care to some extent. Removal of authority inevitably takes away some feeling of responsibility toward the patient; the loss is palpable if not definable. As one might expect, it is mentioned more frequently by older than by younger administrators and is lamented most audibly of all by matrons, or nurse executives, whose position in British hospitals has traditionally been one of virtually unrestricted authority over the nursing service—an area that has usually included what we define as food service, housekeeping and maintenance, as well as actual nursing.

Answers to the claim that hospital spirit has been irretrievably lost in the churning gears of the new administrative machinery divide into two groups. One holds that the charge is rubbish. The same people are ministering to the patient's needs as have always done so, it is pointed out; the idea that the humanitarian spirit is affected is simply a response to wounded vanity, in this view. The other group recognizes some loss here but deems it less important than the tangible benefits which, presumably, will soon begin to flow from integrated planning and action. Plainly, the truth of the matter must vary from hospital to hospital according to the devotion to duty that has prevailed in the past and the amount of change that has now been introduced. Unquestionably, there has been some impersonalization of service, and some loss, in hospitals formerly run by voluntary boards. The fact is, however, that more than half of Britain's general hospital facilities were under municipal or "local authority" auspices before the bell rang on the Appointed Day. Many of these municipal hospitals were vast institutions of 1000 or more beds; some were operated as branches of the local poorhouse. In either case, the humanitarian spirit was spread more thinly here than in voluntary hospitals and the loss, if any, is consequently less significant.

Ultimately, the value to the nation of any system of health care must be measured in the nature and amount of the care that is delivered to the population. On the whole, it seems reasonable to assume that the quality of hospital care under the National Health Service is about the same as it was before. In time, the quality is likely to improve a little, if anything, as the group method brings knowledge of better technics to hospitals whose development has been retarded in the past. The preponderance of opinion among hospital people, in contrast to doctors, is that this factor probably outweighs any loss in quality of care that may be attributed to the impersonalization of hospital service.



The author interviews a patient in a men's ward at Edinbridge. Like many Britons, this man believes that health service should be a charge on all of society.

In judging the success of the hospital service according to the amount of care that is being given, one becomes involved immediately with other factors in the nation's medical and general economy. It is a fact that specialists based on the hospitals are seeing more patients than ever before, by a considerable margin, in hospital outpatient departments, but it may also be true, as most doctors believe, that the bulk of the increase is simply an overflow from the offices of general practitioners who can give only the skimpiest kind of lick-and-promise care under today's assembly line conditions. More significant, perhaps, is the increase in pathological and radiological examinations that most hospitals are reporting; 20 per cent gains over last year are common, and 50 per cent increases are not unheard of. Unquestionably, some of the increase is accountable as careless or unjustified use of "free" services. As one radiologist put it, however, "When you find an actionable narrowing of the colon in a patient whose barium examination would never have been ordered in the old days because of the expense, you make up for a lot of procedures that may be unnecessary."

It is in the admission of bed patients that the worst headaches of the hospital service have developed. With the demand for inpatient care increasing as one would expect under a paid-for service, the number of beds has remained stationary, with the result that the program has operated to build huge waiting lists and intensify the familiar dispute about what is and what is not an emergency. Many management committees have attempted to untangle the admissions muddle by operating central bed bureaus—an admirable effort whose good effects are largely nullified when it becomes necessary, several times a day, for a lay clerk in the bed bureau to decide whether Dr. A's child with appendicitis is more or less emergent than Dr. B's old lady with influenza. Under the circumstances, both emergencies are likely to seem pale alongside the sharply elevated blood pressure of the doctors.

As it has been in many American cities, the bed shortage in Britain is actually a staff shortage. Some 50,000 existing beds, or approximately 20 per cent of the nation's hospital plant, are estimated to be closed today because no staff—and in most cases this means no nurses—can be found to run them. By increasing stipends paid to student nurses and emphasizing "amenities," or living conditions and recreation programs for nurses, the Ministry and the hospitals have speeded student recruitment and eased the shortage a little. In the opinion of many observers, however, the real solution lies in another direction—clearing chronic patients out of acute hospital beds. Contemplating the number of his beds that are occupied by old people whose fractured femurs are mending nicely but who have no homes to return to or no one to look after them, the director of one large hospital remarked, "We've got to remember that the hospital should be a thoroughfare, not a cul-de-sac."

A few of the hospital management committees are becoming aware of the problem and are trying to do something about it—even, in one case, to the point of organizing a home-care service based on the hospital and a volunteer "good neighbor" program aimed at looking after the aged and ailing in families whose own members are away at work most of the day. It seems unlikely, however, that such movements can take more than a small bite out of the problem presented by the chronically ill, which is closely related to the housing shortage and the economic condition of the country generally, as well as to the health service. It may be that to give full effect to the health service it has already initiated, the government will have to provide new facilities for chronics or even large-scale public housing.

To the extent that this is true, it may prove the argument of U.S. conservatives who maintain that there is no such thing as a little bit of socialism, that one step leads inevitably to another until the full Welfare State is ultimately achieved. Possibly this is what Britain's great political philosopher John Stuart Mill had in mind a hundred years ago when he warned, "One of the greatest dangers of democracy lies in the sinister interest of the holders of power; it is the danger of class legislation, of government intended for the immediate benefit of the dominant class, to the lasting detriment of the whole."

In the long run, however, whether the National Health Service in Britain will prove a detriment or a benefit to the whole nation will depend not so much on the administrative complexities that are the subject of today's disputes as on the willingness and ability of the nation's dominant class, labor, to pay for the services it has legislated. It may be many years before the answer to this question emerges clearly.

This is the first of a series of articles about socialized medicine and hospitals, based on observations of Britain's National Health Service program in operation. The second article in the series will appear next month.—ED.

The Care of POLIO PATIENTS

is a job for the general hospital

JOSEPH G. MOLNER, M.D.

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DURING the early part of the last decade it was the usual experience to have hospitals refuse to accept patients suffering from poliomyelitis while these patients were in the febrile or in the so-called communicable stage. This failure to provide hospitalization meant denial of advantages that might have been gained through hospital management.

Denial of hospital facilities, and thereby the denial of adequate medical care, unquestionably contributed toward the development of more serious complications. This statement is made with full knowledge of the fact that methods for treatment of poliomyelitis and methods which have contributed toward the patients' comfort and toward moderate reduction of complications have been available only in recent years. However, with the availability of more modern methods of therapy, hospital care of poliomyelitis becomes even more essential.

CONSIDERABLE RESISTANCE

There is still considerable resistance on the part of hospital administrators to the admission of poliomyelitis patients during the acute or febrile stage. Much of this resistance is based upon the impression that poliomyelitis is a highly communicable disease and that admission of these patients to general hospitals endangers other patients as well as staff members. It is unfortunate that such an impression has become generally accepted as fact.

Public health laws, rules and regulations which have required strict quarantine measures for control of communicable disease have contributed to this false impression. This misunderstanding has been corrected, however, at least on the part of public health administrators, and few states or countries now require strict quarantine of poliomyelitis: It is also necessary that hospital administrators acknowledge that admission of cases of poliomyelitis does not endanger personnel or other patients.

It should be noted that this does not countermand the need for isolation of the patient for at least a two-week period and concurrent disinfection of nose, throat and bowel discharge, together with soiled articles from the patient's room. These precautionary measures also apply to many other sicknesses.

In behalf of the resistance group, it is also true that segregation, as far as possible, is desirable for good and efficient care of poliomyelitis patients. If the community is large enough to warrant the existence of a communicable disease hospital, or if an epidemic reaches proportions of such size that it is advisable to have poliomyelitis sections of hospitals or poliomyelitis wards, these are the choice methods of hospitalization. It is difficult to hold in abeyance sections of small communicable disease hospitals or of any hospital pending the outbreak of poliomyelitis and the presence of a sufficient number of cases to make special facilities and services efficiently usable. It is, however, the responsibility of every community to provide for the care of poliomyelitis, either on a direct physical planning basis, or through a plan for conversion of existing facilities.

As part of the community responsibility, hospitals are charged with the task of making necessary facilities available for care of patients, without regard to the type of sickness from which they may suffer. They also have an educational responsibility which in part at least should be the guiding light in the community to methods by which sickness and disease can best be treated.

If patients suffering from certain diseases are to be denied hospitalization because of possible danger to other patients and staff members, refusing admittance should be on a scientifically sound basis. This is not the case in denial of hospitalization for infantile paralysis victims. When a general hospital fails to admit poliomyelitis patients, it fails to provide the type of care it is pledged to provide in a community; further, the institution fails to meet a highly important educational responsibility. In refusing to accept a certain type of case, for example poliomyelitis, hospitals incite fear of that particular disease in the minds of the public.

SEPARATE HOSPITALS IMPRACTICAL

In most sections of the country it is not practical to provide separate institutions for the care of infantile paralysis. Therefore, facilities in general hospitals should be available for care of this type of patient. Risk involved in admission of poliomyelitis patients cannot be considered as appreciable. It is generally recognized that the over-all incidence of infantile paralysis by geographic areas is low, and that the secondary attack rate is even lower. Only rarely does one encounter institutional or group outbreaks of the disease. The risk to staff personnel and to other patients is considerably greater from certain other diseases, such as the hidden case of tuberculosis, or the developing cases of acute communicable disease which may be admitted during the incubation period. Even pneumonia may be looked upon as offering greater risk than does infantile paralysis.

Obviously, regardless of whether these patients are being cared for in general or communicable disease hospitals, the usual precautionary measures used in the care of other types of disease must be invoked. Such care involves isolation precautions, reasonably careful technic in handling of patients, and careful and proper disposal of body excreta, as has been indicated before.



Photograph by William Rittase, Courtesy, St. Luke's Hospital, New Bedford, Mass.

Student nurses learn how to care for a polio patient in an iron lung.

In part, objection to the admission of poliomyelitis patients to general hospitals has been based upon the fact that adequately trained personnel and equipment have not been available. Modern methods of treatment of infantile paralysis do require special types of equipment and employment of physical therapists trained in the use of this equipment, as well as in application of modern therapeutic technics.

With the recent realization of the important rôle of physical therapy in the treatment of disease, in both the acute and convalescent stages, it is virtually mandatory that every hospital have this service available. A well trained physical therapist should be in attendance and should be provided with adequate equipment, such as hot pack machines, sterilizers, treatment tables, wool and rubberized material for packs, and, of course, respirators and aspirators.

Good physical therapists, with little additional training, can be indoctrinated in the use of this special poliomyelitis equipment and the application of modern therapeutic methods. The use of hot packs represents but a small part of the therapy regimen. Stretching and passive exercise, proper positions and supports and so-called "reeducation in physical movements of the patient" are probably more important. They are the usual responsibilities of physical therapists and are looked upon by physicians as the most important aspect of modern infantile paralysis treatment.

With the shortage of virtually all types of technical personnel, it may be difficult to obtain the services of a sufficient number of physical therapists. When this is true, nurses may be and have been trained in physical therapy procedures. Experience in various sections of the country has shown that specially trained nurses accomplish these tasks very satisfactorily.

Lay persons can also be of assistance in the promotion of modern treatment methods. They can be taught to apply hot packs, how to prepare patients for Hubbard tank and pool therapy, and how to supervise patients during these treatment procedures. Lay personnel can also be of assistance in the application or adjustment of braces and for instructing patients in the use of crutches or wheel chairs. Their assistance in the over-all care of the patient during the convalescent period will relieve the nurse and the physical therapist of many details of care.

It is important, however, to stress the fact that lay persons cannot be trained on the spur of the moment. Therefore, their availability and training pose important problems. These persons must be carefully trained in the technics which they may be called upon to apply, both in behalf of the patient and for their own protection. It is important that well trained professional personnel be used as a nucleus for the organization of a lay staff, for planning and administration of training programs, and for the supervision and control of these auxiliary workers.

In addition to employment of lay personnel for care of patients during the ordinary incidence of infantile paralysis, planning can be extended to training of a sufficient number of persons to meet the critical needs of an epidemic. Outbreaks of infantile paralysis may be so extensive that under no circumstances would enough technically trained personnel be available to cope with the entire problem. In these acute incidences, as well as at times when shortages of personnel are encountered because of a depleted employment market, lay persons can be extensively and effectively used.

If equipment is not available in hospitals for promotion of the most effective methods of poliomyelitis therapy, assistance can be obtained from the National Foundation for Infantile Paralysis, largely through its local chapters. The foundation has on many occasions supplied or lent equipment to institutions for use during an epidemic of poliomyelitis. If trained personnel is not available, the foundation assists in procurement of nurses and physical therapists who are conversant with modern therapeutic practices. This organization will also provide special training for physical therapists and nurses who are on hand but need additional training in poliomyelitis therapy. It is an important responsibility of the hospital administrator to explore all of these possibilities if lack of personnel or equipment represents a handicap in the planned care of infantile paralysis.

Experience in outbreaks of infantile paralysis and the care of patients has taught the medical profession that hospitalization is an absolute necessity if adequate care of poliomyelitis is to be accomplished. Early hospitalization and prompt initiation of good medical care may spell the difference between life and death. The initiation of early medical care with all its modern adjuncts may spell the difference between serious complications leading to life-long deformity and complications which can be relieved or adjusted in such a manner that the patient becomes a self-sufficient member of the community.

There is no doubt in the minds of

the majority of doctors, other professional groups, and hospital administrators that proper management of poliomyelitis requires the availability of the full facilities of a well organized, well staffed and well equipped hospital, that the staffs of these hospitals can be adequately trained in the care of poliomyelitis, and that equipment can be made available without a great deal of additional expense. There is no doubt in the minds of these groups that availability of *immediate* hospitalization is imperative and that long transportation to such facilities and the element of time involved multiply the risk to the patient in death and serious complications.

If there is need for education of the hospital administrator in these facts, there is probably equally as great a need for education of the medical staff, nurses and lay personnel of institutions.

There is also critical need for education of the public because, after all, the major responsibility of hospitals is to give an over-all community service. It does not represent good service to the community when the public is not conversant with the fact that poliomyelitis patients, like pneumonia patients, can be admitted to general hospitals without undue risk to others.

Refusal of hospitals to admit poliomyelitis patients engenders fear in the minds of the public, and no effort is strong enough to nullify this demonstration of concern by professional persons and hospital administrators. The weakest link in any health education program is the failure of educators satisfactorily to demonstrate their own belief in what they teach others.

HOUSEHOLD POISONINGS

IN THE "Conference on Therapy" section of the February 1949 issue of the *American Journal of Medicine* it was reported that the majority of household poisonings occur in children under 5 years of age. In one report listing 158 cases of fatal poisonings in a period of five years in this age group, 45 different substances were listed, but more than half of the poisonings were from strychnine used in cathartic and "tonic" pills.

Dr. Harry Gold, who conducted the conference, cited one case history to illustrate that often the treatment of such poisonings is more dangerous than the poisoning itself. In the case of a 2 year old, the child swallowed (or so it was reported) about 20 cc of a 1 per cent solution of atropine sulfate, prescribed to someone as eye drops. The child was found with a fever of 102, dilated pupils, flushed and restless. The doctor lavaged the stomach; 10 mg. per Kg. of amytal sodium was administered intramuscularly, and the patient promptly went into a coma with shallow respiration, feeble pulse and cyanosis. The next day the child started to recover but what started out as a possible accidental poisoning by atropine ended as a therapeutic poisoning by amytal sodium. Other common household poisonings where it is best to institute no treatment include:

1. Mercury poisoning from a clinical thermometer breaking in the mouth or rectum. There is little chance of fatal poisoning in these instances since the average thermometer contains about one gram of mercury and absorption is slight.

2. Poisoning from matches and possible phosphorus poisoning. There is little chance of poisoning since the highly toxic yellow phosphorus formerly used in matches has been replaced by the nontoxic phosphorus sesquisulfide.

3. Moth repellent articles are made for the most part from the compound paradichlorobenzene, which is comparatively innocuous. It is important that such material be labeled clearly with the exact chemical contents of the container so that proper steps to treat poisoning can be taken by a physician if the chemical content is known.

4. Camphorated oil, sometimes mistaken for castor oil, is a convulsant and is rapidly eliminated so that even after a violent convulsion the patient will probably recover.

5. Kerosene and gasoline. The course of kerosene poisoning is very rapid and about 5 to 10 per cent of the patients die in less than 24 hours. It is safe to assume that the patient who is still alive on the day after a dose of kerosene is likely to recover. Stomach lavage is indicated if there is any appreciable amount in the system, and special care should be taken to avoid aspiration. There are no specific antidotes.

6. Boric acid and borax are often mistaken for bicarbonate of soda. The toxicity of boric acid doesn't seem to be as great as indicated. This poisoning causes fairly prompt gastro-intestinal symptoms and there is no specific antidote.

Dr. Gold asked Dr. Milton Helpern of the medical examiner's office of New York City to report on cases of fatal poisoning found in his office. Dr. Helpern reported that a large percentage of the poisonings were caused by ordinary household materials, including the following:

1. Illuminating gas.

2. Rat poison, containing white arsenic.

3. Material used in extermination of household pests, such as yellow phosphorus used in roach paste and sodium fluoride used in roach powder.

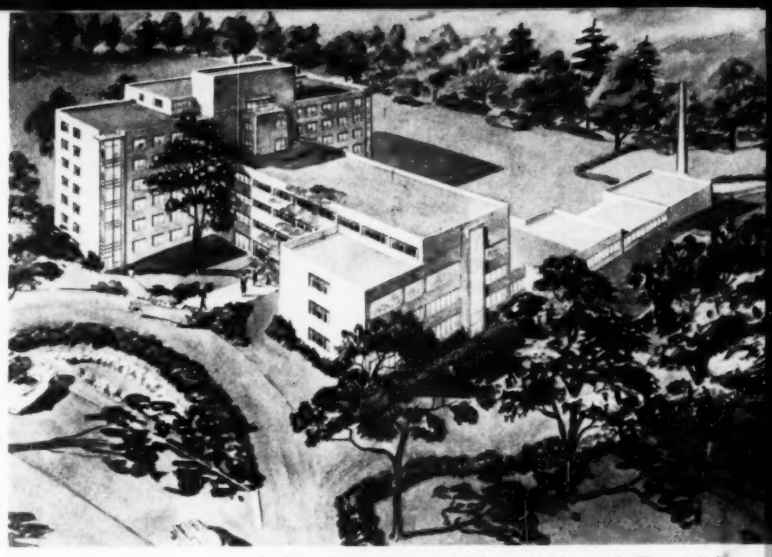
4. Insecticides containing nicotine.

5. Cleansing agents — lye, concentrated ammonia and washing soda, dry cleaning fluids containing carbon tetrachloride which can cause death by inhalation as well as by ingestion, and metal cleaners containing cyanide.

Disinfectants, such as iodine, carbolic acid, and creosote mixtures, produce corrosive action as well as systemic poisoning. Wood alcohol and medicated alcohol are also poisons.

Dr. John H. Dale Jr. of the department of pediatrics of New York Hospital reported that most of the patients with poisoning were between 2 and 3 years old and the most frequent poison was fluoride roach powder. Gastric lavage is performed in the clinic and the signs and symptoms of gastro-enteritis which follow respond satisfactorily to bland diets.

A laxative which contains phenolphthalein is another source of trouble, although nothing but purgation usually occurs. Dr. Dale reported that all children brought into the clinic in the last three years have recovered and he corroborated Dr. Gold's statement that overzealous treatment is often more harmful than the poison. Lavage with tap water is usually the only treatment. Observation for symptoms referable to the central nervous system and treatment of gastro-enteritis with a bland diet rounds out the treatments given. Stimulants and depressants are used only when there is a clear indication for them.—I. GOTTSEGEN.



Architect's rendering of Women's Hospital, Flint, Mich.

Women's Hospital, Flint, Mich.

THE ARCHITECT WAS BLESSED

with a cooperative board

LEWIS J. SARVIS
Architect, Battle Creek, Mich.

THE preliminary work on Women's Hospital, Flint, Mich., was done in the summer and fall of 1946. The site is located on the western edge of Flint and slopes from south to north, overlooking a public park to the northeast. What appeared to be a difficult slope to handle and plan turned out to be the determining factor and the basis of the organization of the plan.

It was possible to place the outpatient department on the south with a grade entrance at an upper level and to have the main entrance come in at grade level one story lower; thus, the second floor of the hospital proper lined up with the first floor of the outpatient department.

The diagnostic facilities of the x-ray and therapy departments and the laboratory were placed on the second floor of the hospital, in a connecting wing; thus, they are located in the center of the inpatient load and immediately adjacent—on the same floor—with the outpatient department.

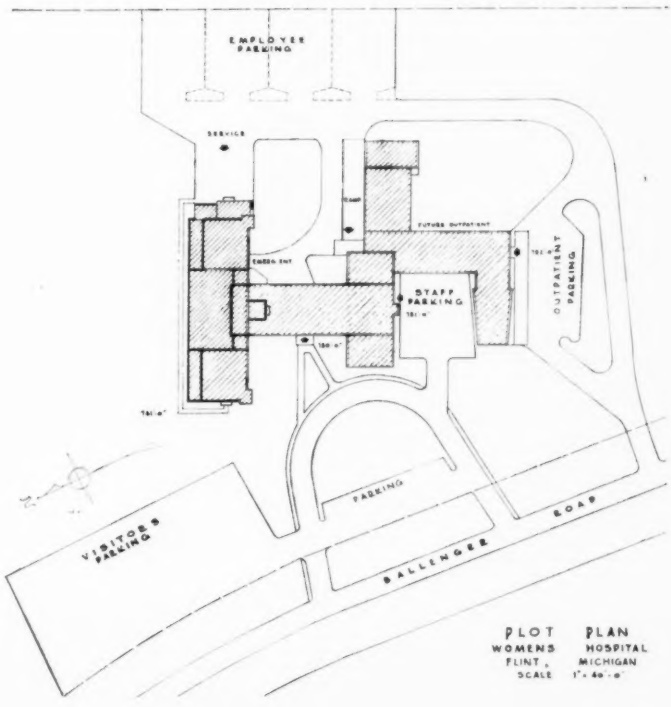
Patient nursing units were originally designed two to a floor, but in a planned reduction in the size of the hospital they were reduced to one unit per floor. The plan concentrates services as much as possible, adapting a modified parallel service type of unit. Travel distances are shortened; the average travel from nurses' station to patient rooms is 36 feet, figured from the end of the nurses' desk to the patient's room door.

The waiting room is immediately adjacent to elevators and out of the circulation of the main corridor. The nurses' station is located in the center of control with the various service rooms adjacent in line.

The wards are concentrated in the center; this shortens travel distance, aids in keeping wings quieter for the single and semiprivate rooms. Doors could be placed in wing corridors, separating the wings from the center section. All patients' rooms are provided with their own toilets.

Subutility rooms with bedpan sterilizers and clinical sink are provided in each wing. The utility rooms comprise three areas—general, soiled and clean. Bathroom units provide tub, shower and sitz bath.

Typical nursing units contain 36 beds; four of the single rooms are the





GROUND FLOOR PLAN

LEWIS J. SADVIS, ARCHITECT

large "1-2" type (adaptable to one or two patients for emergency expansion); the remainder of the rooms are wards, semiprivate and private rooms.

The second, third, fifth and sixth floors are typical nursing units. The first floor contains a pediatrics section and a separate medical isolation unit. The fourth floor is entirely obstetrical. The seventh floor houses the resident doctor and the interns in the smaller center section.

Bed percentages per typical floor are singles, 33.4, semiprivate, 22.2, wards, 44.4.

The center connecting "T" adjoining the nursing units on the first floor contains the administration unit; on the second floor are the diagnostic facilities and therapy unit, as mentioned, with the future outpatient unit to the south. The center "T" on the third floor contains the entire operating suite, which is connected with the surgical nursing unit on the same level.

On the fourth floor, part of this same "T" unit, directly over surgery, contains the isolation nurseries and labor and delivery rooms. This section, of course, joins with the complete obstetrical nursing unit.

The "T" shaped unit on the first floor allows easy access at this grade level to the main entrance of the hospital, with information, cashier and admitting service organized near the entrance. Most of the administrative offices are immediately adjacent, but in a separate wing, and entirely out of the main line of travel.

A smaller meeting room is provided near the staff room, at first floor level, to serve until the outpatient section is built; also at the second floor level, at the junction with the outpatient section, offices are provided for maternal health, prenatal education, planned parenthood, and cancer clinic, and other organizations that are both administrative and outpatient in function.

The staff room, medical library, record room, with adjoining dietary rooms, are grouped together adjoining but separated from the administrative area. The dictation rooms, part of the record group, are so located that the doctors pass directly by them going and coming from their own parking area immediately adjacent.

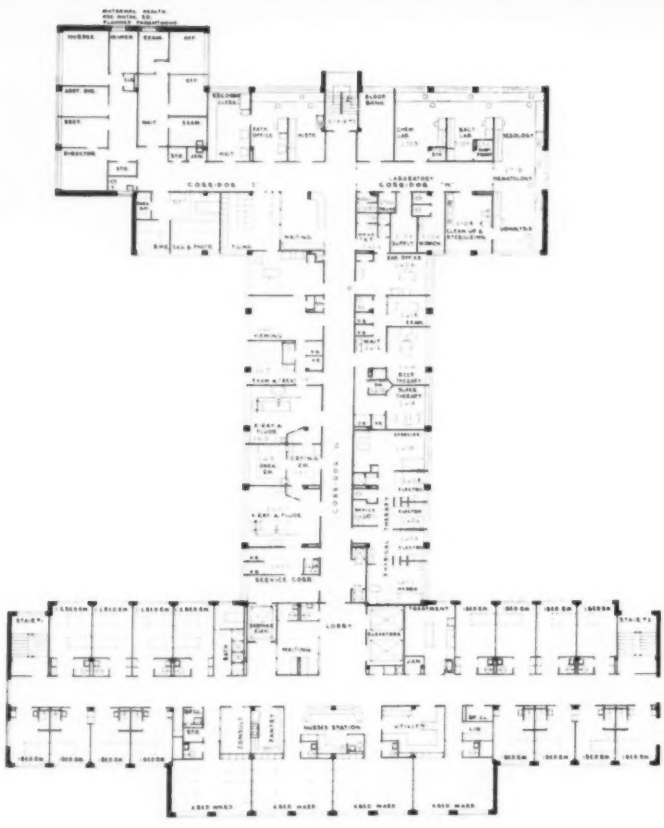
At the first floor level, to the northeast, the nursing units are varied a little in design from other typical nursing units, one being given over to a medical unit, with isolation facilities, and one to pediatrics. The pediatrics section is practically an all-glass department and is placed to gain the benefit of the roof deck.

(*Continued on Page 62.*)



FIRST FLOOR PLAN

On the ground floor are concentrated all dining room, kitchen and food facilities and lockers, the grade slope of the site providing full story height above ground level. The kitchen is directly under the nursing units and provides tray conveyor service directly to all floors above. On the first floor, in addition to the administrative offices, are the pediatrics department and an isolation unit. Second, third, fifth and sixth floors are typical nursing units. The fourth floor is devoted entirely to obstetrics. The seventh floor houses resident doctors and interns.



SECOND FLOOR PLAN



THIRD FLOOR PLAN

The slope of the site, previously mentioned, permits a complete full story area at ground level below the nursing unit on the park side. Here at this same level are all dining room, kitchen and food facilities and lockers, the grade slope providing full story height above ground level. The kitchen is directly under the nursing units and provides tray conveyor service directly to all floors above into the floor kitchen at the center of the nursing unit.

While separate nurses' dining room, with staff area, and an employes' dining room are provided, all service is from one cafeteria unit. The soda bar is part of the main dining room.

Food storage is provided immediately adjacent to the kitchen. A ramp with a short grade slopes down to the ground floor level from the rear to provide for unloading of supplies for various storage departments.

The central sterilizing group is located in the center, near the elevators at the ground floor level, with separate sterile and unsterile dumbwaiters that feed up directly through the center of the hospital into a distribution center available to the nursing units on one side and operating and delivery room units on the other at each floor level. Pharmacy is immediately opposite the sterilizing work unit, convenient to the dumbwaiter.

Lockers provided for nurse's aides are separate from women employes' or nurses' lockers and lounge. Men's lockers are located in another section of the building.

FOUR PARKING AREAS

A study of the roads will show four distinct parking areas: a large one in front for visitors' parking, feeding directly to the front entrance; a separate area for doctors' parking, which feeds directly to the first floor level, next to record, dictation and staff rooms, and immediately adjacent to the director's administrative unit; the employes' parking area, and the outpatients' parking on the upper level, which opens directly to the future outpatient department.

Emergency cases come in from the rear at the first floor level to a small emergency clean-up and recovery unit provided close to the door and the rear entrance of one of the elevators. The main emergency room is adjoining—but outside of—surgery on the third floor. Thus, an emergency case is brought in at the emergency entrance

and can go immediately into the unit at the entrance level, or be taken in the elevator to the emergency room or surgery at third floor, or to the x-ray department at second floor level, or can become an inpatient, without getting into the general circulation areas.

It will be noted that the main emergency room above is directly related with the fracture unit and is adjacent to all surgical activities, but is well isolated.

Nonambulatory cases can be admitted at first floor level and go by elevator to the floors above, without entering the general circulation areas except when they arrive in the nursing unit. Also, doctors can use this secluded means of vertical travel to go into surgery or delivery section, without being observed from the nursing units. Maternity cases can also go directly to labor rooms without entering a large part of the general circulation area.

NURSERIES SEPARATED

On the maternity floor, nurseries are grouped with each maternity nursing unit. Premature and isolation nurseries are separate and partially isolated in the "T" wing. Delivery and labor rooms are completely isolated at the end, but available at the same floor level. The labor rooms are in one bank immediately adjacent to the delivery room. Nurseries follow the pattern of two rooms placed adjacent to a common examining and workroom.

Both obstetrical and surgical suites will be completely air conditioned. There will also be a special group of conditioned allergy rooms.

On the surgical floor, in the "T" wing, will be found an excellent department with control, clean-up and storage facilities well centralized. The various stretcher storage spaces are located near the operating rooms they serve. Separate locker rooms, but one common lounge, are provided for male and female doctors. The stairway shown at the end of the surgical wing is only a fire tower exit, to comply with the regulations.

The hospital contains 220 beds, in six floors, expansible through the 1-2 bed room arrangement to 259. Based on the 220 bed capacity, it contains 5672 cubic feet per bed, not including the outpatient department; including the outpatient department, it contains 6538 cubic feet per bed.

The hospital will have piped oxygen throughout and suction where required; also an automatic tube system. The floor system is a flat slab type without beams or dropped column heads, to reduce height and allow piping to be installed without the usual beam interference. Structural frame is reinforced concrete.



FOURTH FLOOR PLAN



FIFTH & SIXTH FLOORS TYPICAL

The architect was blessed with a cooperative hospital board, with an efficient separate building committee, headed by Sidney Stewart Jr., and Margaret E. McLaren, an excellent superintendent with comprehensive views and wide experience.

DEBATES ON SOCIALIZED MEDICINE FEATURE SPRING CONVENTIONS

SOCIALIZED medicine and its implications for hospitals was the topic of the hour as state and regional hospital associations met for their annual conventions around the country last month. At Asheville, Biloxi, Chicago, Kansas City, Houston, San Francisco and elsewhere, hotel meeting halls and dining rooms echoed with warnings that it can happen here—and may, unless hospital and medical groups get busy and double their efforts to spread voluntary health insurance, support reasonable legislation for medical and hospital aid, and combat the proposals for compulsory insurance with every weapon in sight.

In at least two places, Chicago and Asheville, government spokesmen answered back. Voluntary hospitals are on the financial skids, and at the same time the people need more, not less, hospital care of the kind they can't pay for, assistant federal security administrator John Thurston told the Tri-State Hospital Assembly banquet in Chicago. He described federal health insurance as a social security measure that would prevent, instead of precipitate, the socialization of medicine. At the Carolinas-Virginias Conference in Asheville, Mrs. May Thompson Evans rang all the changes on a familiar theme: Too many Americans can't afford the kind of medical care the doctors know how to provide; many doctors are impatient with the tactics of medical leadership and want a new medical deal.

When they weren't listening to these heated debates, the thousands of hospital people attending the meetings were hearing and taking part in discussions of accounting and purchasing, medical records and relations, nursing and maintenance and all the other complexities of administrative life in these uncertain times. A partial record of their deliberations and decisions, as reported by various staff members and friends of The MODERN HOSPITAL, follows.

Tri-State Assembly

By Jane Barton

CHICAGO. — Attendance announced Wednesday afternoon (last day) as "past 6500 mark." Badges distinguished administrators (orange), department heads and miscellaneous (blue), exhibitors (red). Purchasing agents also wore orange badges, the idea obviously being to help exhibitors spot the people who would do the buying. Only trouble: red and orange too similar—hard to distinguish between buyer and seller.

Two Good Fights: Panel session Monday night revolved around "Financial Considerations in the Rendering of X-Ray, Laboratory and Anesthesia Services to Patients in Hospitals." Seemed audience participation was subordinated to private war going on between specialists on one side of table and Buerki-Bradley-Hamilton combine on other. Other participants who got in occasionally: Frank Selfridge and Nellie McNamara, trustees of Highland Park Hospital and Women's and Children's, respectively. Specialists were: Anesthesia, W. Allen Conroy, St. Luke's Hospital, Chicago; Radiology, J. Edwin Habbe, Milwaukee, Chairman, Commission on Hospital Standards, A.C.R., and Pathology, George Milles, secy.-treasurer, Illinois Society of Pathologists.

Milles and Conroy particularly vocal, upholding right of specialist to absolute autonomy (not to say autocracy) in own department. Should hire and fire, set fees, do own disciplining—responsible to no one but medical staff and own conscience. Hamilton needling them about legal responsibility of trustees for welfare of patients, backed up by Miss McNamara, who is legal expert. Conroy didn't know or believe that the trustee had any legal responsibility. Says if anybody gets sued for acts of anesthesia staff, it's the doctor, and the hospital is not to blame.

Consensus of Specialists: Hospital should furnish everything but medical care, and should leave all decisions *re* treatments to doctors. Bradley says hospitals favor "academic freedom" for specialists, but they should be paid. All agreed that method of payment should be based to some extent at least on local conditions. Specialists insist that no limits should be put on earning power, regardless of what other doctors are making. Only other area of agreement: Hospitals as guilty as specialists in overlooking patient in heat of battle over finances. Questions from floor pretty much same stuff over and over: Who should set fees? What is fairest method of payment? Who controls actions of medical staff? Why don't docs police themselves instead of protecting each other?

For names of new regional association officers, see Page 142.

Fight No. 2 Compulsory Health Program vs. A.M.A.: John L. Thurston, assistant administrator for program (all-time high in obscure titles), Federal Security Agency, going in for Ewing on need for administration's health bill. Sounded warning on British experience: too little insurance too late, and now look at the darned thing. Harps on Abraham Lincoln thesis: "Purpose of

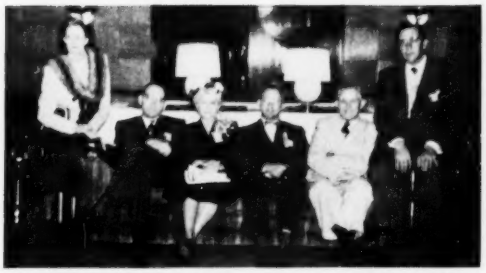
(*Continued on Page* 126.)



TRI-STATE: Left: Dr. Dwight Barnett, Detroit; Center: Mrs. Martha Ballard, Detroit, Mrs. Alta M. La Belle, Chicago, Waldo Buss, Chicago; Right: Esther Hedegard, Detroit, Margaret Purcell, Chicago, and Harriet Berger, Chicago.



CAROLINAS-VIRGINIAS: L. to R.: President E. T. McKeithen; James M. Daniels; Mrs. May Thompson Evans, Federal Security Agency; W. P. Earngey Jr., and Dr. G. Westbrook Murphy.



MIDWEST: Mrs. Mabel H. Mooney; President Charles H. Newell; Past President Regina H. Kaplan; President-Elect Roy R. Anderson; R. L. Loy, treasurer; Moody Moore, V. P.

Mid-West Hospital Convention

Contributed by Francis J. Bath

KANSAS CITY. — The time is gone when small community hospitals may regard the care of the mentally ill as the sole responsibility of the large hospital; the small hospital must assume its full share of this responsibility today. This is the view of Dr. John R. Adams of the Menninger Foundation, Topeka, Kan., in an address which featured the twenty-first annual convention of the Mid-West Hospital Association here last month. The theme of the convention emphasized problems of the small hospital.

Urging greatly expanded facilities for care of the mentally ill in general hospitals, Dr. Adams declared that the total flexibility of institutions is enhanced when such facilities are available, providing, as they do, specialized care for the acute toxic state, for medical problems with delirium, and surgical patients in whom an encephalopathy or acute functional psychosis develops postoperatively. The needs of the disturbed obstetrical patient and many neurological patients also are better met when such units exist. The general hospital offers a place of reassurance and hope for such patients, he said, in place of the fears and threats of confinement in an institution designed primarily for the chronically ill and the incurable.

"The obligation to provide facilities for the mentally ill is an important part of the total social responsibility which the organized medical establishment must accept. Where legitimate demands are not met, the institution fails its community," declared Dr. Adams.

"Management wants good workmanship, loyalty and teamwork, a fair day's work for a fair day's pay. Employes want security, opportunity and understanding," declared Richard E. Roberts, director of the employe relations department, Ford Motor Company, Dearborn, Mich., in summarizing his presentation on "Human Relations in Industry" at the opening general session. An effective program of human relations should provide the common ground upon which the wants of both management and employes may be realized, he said. "We in management have an important function to perform in protecting the interests of our employes. What is needed today is industrial statesmanship

(*Continued on Page* 130.)

Association of Western Hospitals

By Alden B. Mills

SAN FRANCISCO.—A possibility that hospital costs may have passed their peak was a hopeful note sounded at the Association of Western Hospitals' nineteenth annual convention which attracted nearly 3000 people to San Francisco, May 9 to 12.

Three hospitals in California reported lower operating costs for the second half of 1948 than for the first half, according to Dr. Marcia Hayes, assistant chief of the bureau of maternal and child health of the state health department. Dr. Hayes made no such prediction but merely reported the fact, which is so contrary to general trends.

As usual, the nursing situation occupied a large share of the program, with the Brown report being extolled and criticized at the same session but all parties agreeing that the report was very beneficial as a stimulant to more fundamental thinking about the future of nursing. Dr. Howard Naffziger, San Francisco surgeon, regretted that Dr. Brown had limited her inquiry so largely to nurses and a few hospital administrators and so generally neglected to obtain and consider the points of view and facts of physicians.

Anna M. Steffan, president of the California League of Nursing Education, outlined steps to be taken now to bridge the gap between the kind of nurses we have and the kind we need. She suggested: (1) supplementary programs to fill in the omissions in basic nursing education of many nurses now registered, especially in such fields as psychiatry, pediatrics and obstetrics; (2) in-service training programs to inform nurses of new technics and procedures, and (3) advanced nursing courses by colleges and universities to prepare nursing specialists.

Miss Steffan deplored the fact that there are almost no scholarships avail-

(*Continued on Page* 138.)



TRI-STATE: Left: Dr. Martha O'Malley, Indiana State Health Department, and George Hendrix, Illinois State Health Department; center: E. G. Ince, trustee, Geneva, Ill.; right: Dr. James Smith, Jacksonville (Ill.) State Hospital.



HOUSING PROJECT FOR GRADUATE NURSES

Housing Helps to Solve the Nursing Shortage

H. E. RICE
Business Manager, New England Sanitarium and Hospital, Melrose P.O., Stoneham, Mass.

MONEY is not everything. In fact, it is only a substitute for what people really want. When this is recognized it becomes obvious that there are other answers than money to the problem of nursing shortages. One of the answers is to provide what is really wanted—not its money substitute—and one of the things that is really wanted is comfortable adequate housing among congenial friends.

Acting upon this premise in an effort to meet nursing shortages and minimize the turnover of personnel, the New England Sanitarium and Hospital of Stoneham, Mass., some two years ago embarked on a housing project for graduate nurses. Small apartments were built in which the nurses would have their private rooms, heated and furnished, each complete with a tile bath, and a kitchenette equipped with a four burner gas stove and oven, sink, electric refrigerator, and a dish cupboard complete to bread board and spice jars. Each kitchen arrangement includes a built-in breakfast nook seating two. Four units were constructed so arranged as to form two court ways and providing for a total of thirty-two graduate nurses.

Adjacent to these buildings garden plots were laid out and the girls are encouraged to have their own gardens for diversion in off-duty hours.

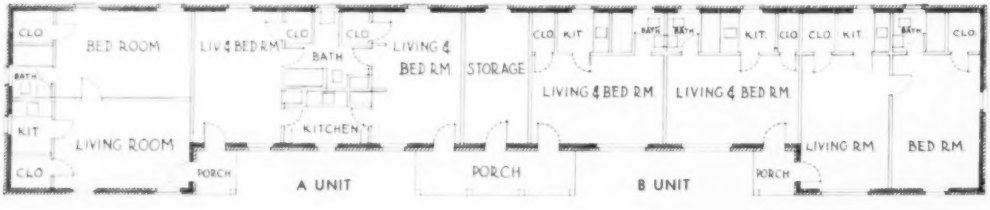
Three distinct rooming arrangements are provided in order to meet the wishes of the girls, ranging from the gregarious to the entire isolationist. The first is an arrangement of two rooms—a living room, furnished with divan, easy chairs and library table, and a bedroom with twin beds, two dressers, two closets, and chairs. Connected to these rooms are a kitchenette and a tile bath. The second arrangement provides for separate rooms with kitchenette and bath between the rooms so that each girl may maintain her own room in privacy but shares kitchenette and bathroom facilities with her one neighbor. The third arrangement provides private room with its complete private bath and kitchenette.

Radiant heating is provided by means of hot water coils laid in the floor. The separate apartments have their individual thermostatic controls by means of which the circulation of water in the floors is regulated. Superimposed upon the whole heating system is an outside thermostatic control which regulates the temperature of the water that circulates. Even temperature in the rooms is thus maintained in New England's coldest winter weather.

Rentals are on a nominal basis, considerably less than current rates in the community. These rentals include gas for cooking.

Experience has indicated that the nurses, even though taking their main meals in the hospital cafeteria, delight in having the opportunity of preparing some dainties to meet their own tastes and they take pleasure in having this added measure of home life.

The result in added nursing personnel has been most satisfactory to the hospital. While undoubtedly there is no one answer to the great problem of providing adequate nursing, among the many answers that contribute to the solution surely comfortable pleasant housing among friends is one.



Principles, technics and problems of

ADMITTING PATIENTS

SIGMUND L. FRIEDMAN, M.D.
Director
Mount Sinai Hospital
Cleveland

THE function of the hospital admitting officer is simply to admit patients to the hospital.

In the process, she works not only with patients and their families, but also with staff physicians, nonstaff physicians, nurses, social workers, interns, telephone operators, information clerks, pages, hospital administrator, outpatient director, cashier, collection clerk, and, sometimes, the press. Her most important and probably most frequent contacts are with the patients and professional personnel; these constitute the hospital's public, or its direct pipeline to that public. And this the admitting officer must never forget. Should she forget it but once, and no more, that lapse of memory may well plague her and the hospital for years. For, somehow, the patient or doctor whom she treats as if the hospital owed him nothing always turns out to be a distant but beloved relation of a "Big Giver" or a close friend of *"that"* board member. This is aside from the fact that, in the broadest sense, she may have mistreated a patient.

NO EXCUSE ACCEPTABLE

There is no excuse for mistreatment of patients, and none should ever be accepted. Excuse it once, whether it be by admitting officer, nurse, intern or staff doctor, and you have started a snowball rolling downhill.

This, then, is the admitting officer's first lesson.

Her next is that each patient is a unique human being, differing from all other human beings; a human being with a unique past, with an all-too-frequently troublesome present, and with a future and an aspiration for that future.

The admitting officer must understand the full implications of what we mean when we speak of the reciprocal relations between social factors and the prevention, production and aggravation of disease on the one hand, and, on the other, the promotion and maintenance of physical and mental health. The admitting officer must somehow be made to understand that nothing in the individual's environment escapes notice, that everything in that environment registers indelibly on the individual, and so affects him and, inevitably, his health.

The admitting officer must understand that many diseases are generated and nurtured by poverty and that many go far toward producing it. She must understand that the poverty which leaves an individual without the means of mere subsistence is the destitution of the family and should be the scandal of society. She must understand that the patterns of living, the habits and diseases of the individual are those of his family and his society, and that the individual cannot be divorced from his family or the family from society. She must understand — *and sympathize with* — the psychology of him who is compelled to beg, hat in hand, for keep.

It is not necessary, of course, that the admitting officer know the details of the relationships between individual diseases and social or physical environment. But, since she must write her understanding into her every act, it is necessary that she appreciate these basic facts as an all-governing, all-pervading "patient-concept."

The admitting officer need not be a trained social worker to appreciate this "patient-concept," although some hospitals have believed so to the extent of placing the admitting office in the social service department. Others have had social workers in the admitting office but under the supervision of the administration. Still others have nurses. The majority, however, have lay persons. Any of these arrangements can be satisfactory inasmuch as understanding and appreciation of this "patient-concept" are not given solely to the graduates of any one particular school.

With this "patient-concept," the admitting officer will be able to place her duties in their proper perspective; she will be able to evaluate correctly the importance of the cards she prepares for the switchboard, for the information desk and the bedside, as well as the telephone calls she makes to the house officers and the referring physicians. With this "patient-concept" she will appreciate that the admitting procedure is essentially an interview with a preoccupied individual, who is frequently ill, frequently frightened, frequently obsessed by a sense of guilt and almost invariably reacting to the illness and the hospitalization.

INTERVIEW IS THE ESSENCE

Since the interview is the essence of the admitting procedure, it alone remains the same through the years. Everything else changes from year to year, and differs from hospital to hospital, almost from patient to patient. The cards, the forms, the consent slips, the telephone calls: these are the nonessentials; these are the things that change. The interview with the patient alone does not.

Let us, therefore, examine it.

There are two sides to the admitting interview: the admitting officer on one; the patient and his family on the other. And what we say of the patient holds, almost without exception, equally well for his family. We have, therefore, included in this discussion on the interview both family and patient in the word "patient," separating the two deliberately for the exceptions.

The patient comes to the hospital for one reason only: he is ill, physically or mentally, or both. He may have come either out of a ready acceptance of his need for assistance or because he has been made to come. In the former instance, he will be more cooperative than in the latter, but he may, nonetheless, be frightened. He may be frightened by his illness; illness may never have struck him before, and physical strength may have been his boast for many years. The removal of this prop produces an even more

profound loss of the sense of security in such an individual than it does in one who has had illness as a constantly recurring phenomenon all his life.

The illness may be associated with a high mortality; it may be minor, but with serious possibilities, or it may bring to the surface long buried memories ("My father had acute indigestion. It turned out to be a coronary which eventually killed him. Maybe this pain is due not to gall bladder disease but to a coronary. How can the doctor be so sure it is not? He took only x-rays, not an E.K.G."). Or, the patient may be frightened by the hospital, not necessarily by its antiseptic odor or its awe inspiring appearance of impersonality but rather by the idea of the hospital. (He may have been told some months before by his physician in a very off-hand manner, "If we can't find out what's the matter with you, we'll have to hospitalize you for a few days. Nothing much, I'm certain, but we've got to make sure.") Or the patient may be frightened by some superficially forgotten memory: a grandparent taken from home in an ambulance, never to return. (What strikes greater terror in the heart of a child than seeing a god-like adult being carried into an ambulance and the doors relentlessly shut?)

MAY BE ASHAMED

Again, the patient may have had his illness for a long time with his ability to "take it" reduced to so low a level that almost anything produces fear. Or the illness and the hospital may actually be frightening; this is typically so in many patients with mental illness since, added to the fear produced in some phases of these diseases, the patients have been conditioned by our society to be ashamed of their illness and afraid of hospitalization.

To these fears must be added the almost ever-present worry of the parent about his family, the breadwinner about his finances, the child about separation from his home and family and bed and toys: everything that means security to him.

To both must be added, more frequently in ward patients and the illiterate, a conviction that the hospital will "experiment" on them, that they will be permitted no say whatever in what will be done to them, and that the motives, abilities and interests of the hospital must be scrutinized with suspicion. And, finally, in ward patients, there is the reluctance to complain when they get "something for nothing"—even though it is theirs by right, not by the grace of those who are better off.

All these, however, are beneath the surface. Few patients, if any, will spontaneously and immediately tell what disturbs them; many could not even if they would. Their fears, their insecurities, anxieties, worries or suspicions are their own—at least until they can be unearthed by a friendly and sympathetic physician or social worker. But, since these emotions are present, they do affect people. And they frequently do so by making them withdraw into themselves, by making them irritable, confused, aggressive, demanding or even threatening. It is these superficial expressions of deeply seated emotions which the admitting officer must comprehend if she is to be neither disconcerted nor antagonized. This understanding is only rarely instinctive; years of experience and willingness to learn and be taught are almost invariably necessary.

The attitudes struck by patients are not the only things to be learned. Almost and possibly just as important are the purposes and technics of the interview. What the admitting officer seeks to learn depends upon the hospital: whether it is a so-called "teaching" institution, a research institute, a hospital for patients with long-term illness, or with mental disease, and so on. It depends upon whether the patient is referred by a staff physician and comes prepared for admission to private facilities or is referred by the outpatient department and is able to pay, if at all, for only ward care. It depends upon whether the patient requires immediate hospitalization for an emergency or hospitalization in the future for an elective operation.

However, since both inpatient and outpatient department physicians are usually well acquainted with hospital policy concerning the types of disease admitted, the bulk of "admission" consists of the determination of financial suitability.

In order to do her job well and justly, the admitting officer must neither permit the patient to pour out his heart without end nor allow herself the luxury of asking factual questions brusquely or curtly. She must limit her goals and hold to her restricted function. She must quickly establish a friendly relationship between herself and the patient, and create confidence in the hospital as well as herself. The technic she uses will, of course, vary from patient to patient, but the variations will be variations on a single theme. She must be, and not merely pretend to be, interested in the patient and in what he has to say.

The admitting officer must be friendly, not overhearty in greeting or overconfident in manner. (The patient's surest response to that sort of attitude is, "What does she care? She's not sick.") Pretense, especially in an interview, is readily discovered. The admitting officer must ask the questions simply, listen and speak only after the patient has made a complete statement. One of the quickest and surest ways to stop someone from expressing himself adequately is to interrupt. But to comment with an air of superiority, to pass judgment, or to criticize is certainly the quickest and surest—as well as one of the most damaging. She must not argue with the patient on anything at any time since this, too, will stop the patient from talking and destroy that relationship which is important to the hospital and vital to the patient's welfare. (It may take several interviews by physicians and social workers to overcome the antagonism built up in this initial interview in the admitting office; sometimes it can never be overcome.)

CANNOT ALTER PREJUDICES

The interview in the admitting office, because of its nature and brevity, cannot alter any of the patient's basic convictions or prejudices. Attempts at modifying them may only make the patient verbalize them more forcefully and convince him that the hospital always was, is now, and will forever continue to be in the wrong about whatever it does.

The admitting officer should attempt to relieve only those anxieties which center around the financial obligation of the patient to the hospital and some superficial fears of his anticipated hospital experience. She will, if she is worth her salt, discover through the interview many problems that fall within the area of medical social service; she may, for example, find that the hospitalization has aroused greater than ordinary anxiety, or that the hospitalization is merely the most recent in a series of ever-increasing burdens thrown on a few bewildered members of the family who seem intelligent and willing enough to work their

problems through with trained assistance; or she may ascertain that the elderly parent, who insists that her children are doing everything they can for her, really is unwanted, has gone from one child's home to another's for years, and is now asking for admission to the ward because her children are not willing, or are unable, to pay for private medical care.

Although her discussions with the patient must be honest, she does not have to tell the patient everything at once; she can reserve some things for later discussion with the family, the cost of hospitalization, for example. Full knowledge of the charges of anticipated diagnostic studies or drugs may aggravate a hyperthyroidism, increase the angina of a coronary occlusion or precipitate a renewal of the symptoms of a quiescent ulcerative colitis. It would, of course, make matters worse if the admitting officer were to talk this over with the family alone—and then permit the bill to be sent to the patient (this is done too frequently).

CONCEAL FINANCIAL STATUS

The admitting officer must realize that the patient will frequently conceal his true financial status in the belief, mistaken or not, that it may prejudice his chances for admission. She must, therefore, learn to evaluate every answer in the light of all others. Some patients may inflate their income, out of fear lest they be turned away if they cannot pay full rates without borrowing. Such a misrepresentation will be uncovered by a general knowledge of the average income which the patient's occupation yields and a rather detailed knowledge of residential neighborhoods and housing conditions.

Others may minimize or even belittle their income. This type of deceit usually requires more than knowledge of occupation, incomes or neighborhoods to be corrected; one gets a "feel" for this sort of thing.

The admitting officer must learn to spot trouble areas in the patient's thinking and feeling. This she does most easily, perhaps, by listening to the manner in which a patient discusses the problems brought up in the interview. A deliberate by-passing may mean as much as does a great deal of excess emotion.

The admitting officer must realize that some of the things she seeks to learn the patient may never have told a member of his family, let alone a stranger; then she not only must hear what the patient says but must discover what the patient cannot say without help or will not without assistance or gentle prodding. And she must remember at all times and in all places that everything she learned in the interview, even the very fact of the interview itself, must never be disclosed; its confidences must remain inviolate.

Finally, she must know and understand fully that she, too, has sentiments, attitudes, likes and dislikes, given her by her own past which she must suppress to the very best of her ability, because they will, if she permits them, affect her relations with the patient and influence her judgment.

If properly conducted, the interview will have been brief. It will have relieved the patient of some of his worry; given him increased confidence and hope in the hospital, and made it easier for him to cooperate with physicians, social workers and nurses.

The interview (abbreviated or complete) will also have given the admitting officer those facts she requires in order to determine the patient's eligibility. For hospitals must restrict the types and numbers of patients admitted to both the wards and private pavilions if they are to render good, let alone the best possible, service.

The most frequent restriction placed on the admission of private patients is included in the phrase "medical suitability." Some hospitals are not prepared to accept responsibility for patients with mental disease; others are not permitted by law to accept such patients; some prefer not to admit patients with known active tuberculosis or venereal disease; still others restrict on the basis of color.

The largest number of restrictions are, however, placed on ward admissions. Ward patients are usually not admitted (except in case of an emergency or to an occasional governmental hospital) without detailed questioning. They must be medically suitable, and to be medically suitable, a ward patient must be certain not to have any of the diseases aforementioned and many more—usually long-term illnesses.

When these latter are barred from admission, it is because the patients and their families have frequently exhausted whatever financial resources they ever had in the first place; because the staff physicians are almost invariably more interested in the acutely ill (in the wholly erroneous belief that acute illnesses are more instructive and more interesting, because response to treatment is relatively swift), and because there is a much greater turnover of acute than of chronic patients. Discriminatory policies in an acute general hospital are, however, usually not severe enough to eliminate the influence of the area in which the hospital is located. For, particularly in large urban centers, small "ghettoes" have become established through the years in which many factors influence hospitalization, such as the prevalence of certain diseases (on either a long-term or short-term basis), and even the attitudes of the people towards hospitalization.

EXPECT SOME PAYMENT

Many hospitals expect their ward patients to pay for at least some of their care unless they live within carefully drawn zones, though many will accept free patients living outside these areas if they are "unusually good teaching material." Still others require that ward patients, except in emergencies, be referred by staff physicians—a practice which encourages the sick poor (even the truly medically indigent) to pay private fees to gain admission.

Some ward patients coming to the admitting office are thus automatically eliminated; they never really get as far as the interview. From those who do, the admitting officer seeks first a whole set of data concerning the patient: full name, maiden name (if any), address, telephone number, date of birth, marital status, sex, birthplace, nationality, race, religion, name of referring and attending physician, name, address and telephone number of nearest relative or friend and date of previous admissions to the hospital and occupation.

Second, the interview will have given the admitting officer the information needed to determine the patient's financial suitability. This information is usually sought only from patients applying for ward care though occasionally from patients desiring semiprivate facilities. In either case, the data must be obtained with the utmost tact and consideration, because patients, especially those barely able to pay their way, are likely to misconstrue the reasons for the questions, the questions themselves, and the manner in which the questions are asked.

Most patients are worried about the cost of medical care which they know

from experience or hearsay to be high. Most, too, (despite what some may say) would rather not get something for nothing. Wage earners are worried about the effects of their illness on their earning capacity and on their family's ability to get along without their contributions, for they, unlike some of the rest of us, have not ignored the fact that there is a marked difference between their needs and their ability to support themselves in health and sickness.

QUESTIONS TO BE ANSWERED

These concerns of the patient are the interests of the admitting officer. She must know of them if she is to do her job well and if she is to answer such questions as:

How large is the family? How many wage earners does it have? How many dependents? What is the patient's rôle in the family?

What is the patient's exact occupation? Is it seasonal?

How much does the patient earn? Or, if the patient is a member of a family, how much does the family earn? To what extent will the family income be affected by the patient's illness?

How much does the family spend for necessities? For luxuries? For special responsibilities?

Does the family have any savings? Does the patient carry any insurance?

How long will the patient be totally incapacitated? How long partially? Will the patient ever be able to return to his original occupation? Will he lose his job because of this illness?

Has the patient or a member of his family been ill within the past year or two? If so, how long did the total illness last? How did it affect the family? How much did it cost the family?

These questions must be so asked that the patient—or his family—is not made to feel abject. They must be so asked that the patient does not feel that he has been made to declare his indigency. Few, if any, of us would endorse the requirement of some communities which, according to Franz Goldman, still insist that "a patient applying for medical care at public expense . . . sign a declaration like the following:

"I, the undersigned, realize that treatment and medicine provided free . . . is for those who cannot pay the same, and hereby swear that my condition is such that I must seek relief."

Few of us also would use eligibility for public assistance as a yardstick to measure eligibility for ward admission; most would use ability to pay the costs, or, put another way, we would use some definition of "medical indigency." A good one is that recommended to the American Medical Association in 1938:

"A person is medically indigent when he is unable, in the place in which he resides, through his own resources, to provide himself and his dependents with proper medical, dental, nursing, hospital, pharmaceutical and therapeutic appliance care without depriving himself or his dependents of necessary food, clothing, shelter and similar necessities of life, as determined by the local authority charged with the duty of dispensing relief for the medically indigent."

The admitting officer cannot therefore discover whether the patient is financially eligible for ward admission (on a free, part-pay or full-pay basis) until she has made a rapid mental calculation of the possible cost of the illness based on the length of the anticipated hospitalization, cost of diagnostic studies, possible special nursing care, probable post-hospital needs in the form of convalescent care, special diet, physical therapy and household help. She then balances one against the other and makes some sort of decision, the value of which depends upon her ability and her experience, upon the information obtained, and the accuracy of available family budget studies made in the community. Frequently, even the ablest and most experienced of admitting officers come to the wrong conclusions. It is then that they prove their value to the patient and to the hospital, for, vaguely dissatisfied, they mark the patient for further reevaluation of his problem, call him to the attention of the social worker, and then personally follow him throughout his hospitalization period.

The admitting officer's decision of what the patient can pay must not be swayed by sentimentality. Free care indiscriminately given is unfair to the hospital and to the community which supports it, as well as to the physicians who give of themselves freely to the indigent, and who are dependent for their livelihood upon patients able to pay for their medical care.

Neither, however, should the admitting officer go to the other extreme and, by rationalizing that "business is business," attempt to extract the next to the last, if not the very last, dollar from each patient. This practice is dangerous for the hospital because it trifles with the patient's welfare and risks community condemnation; for the patient because it may aggravate his illness or force him to borrow; for the family because it may compel it to reduce its food budget or go without fuel; for the community because of the damage done to one of its members. Or, as Goldwater put it: "If hospital solvency is purchasable only at the price of soullessness, it might be better to risk insolvency, and to trust the community to come to the rescue."

The admitting officer must remember the principles behind, if not the actual words of, the recommendations of the American Public Welfare Association in 1939:

"Persons already accepted for maintenance at public expense should be accepted, without further investigation, for medical care at public expense.

"The determination of medical need should be a medical responsibility and should precede the determination of financial eligibility.

"Determination of eligibility should not delay necessary treatment."

PHYSICIANS ON ALL SIDES

As if all this were not enough, the admitting officer has the physicians always before, behind and on either side of her. They are one pipeline to the public, frequently the philanthropic public; they are always on the hunt for ward patients bedecked with diamonds and precious furs; they are ever ready to shout "favoritism" if *their* private patients are not admitted immediately—and never mind the next fellow's cry of "discrimination" or the other's bellow of "nepotism." They want only "interesting cases" admitted to *their* wards, and the "uninteresting" can go elsewhere—to either the other fellow's ward, or someone else's hospital. They want no "chronics." And when they are doing investigative work on a special phase of a rare disease, they want large numbers of patients with that particular phase of that disease in the wards at all times (sometimes without regard to hospital policy).

But—and this, too, the admitting officer must always remember — the hospital owes a debt to its physicians and to all the physicians of the com-

munity. This debt can be acknowledged not only verbally but in acts committed daily. Admission and discharge policies, for example, should not be made or changed without previous consultation with and approval by the medical board. The policy stating the procedure to be followed when an applicant for ward admission is considered able to afford the services of a private physician should be set only in the same way.

The referring physician, whether staff or nonstaff, should be notified by telephone immediately on the patient's admission, and that should be followed up with a formal notice.

The physicians in the community will be better satisfied if they know that the hospital uses a guide for estimating the minimum family budget (preferably one that has been provided by an outside community agency) and that its standards for economic eligibility of patients for ward admission have been agreed to by the local hospital council or medical society.

WARD BEDS PARTLY EMPTY

The physicians, as well as the hospitals, have had a hard time for the past few years, but practice is now rapidly becoming, at least in the larger cities, much less strenuous. However, the shortage of beds so prominent throughout the war continues. This shortage is, incidentally, illusory in many places for analysis of hospital figures frequently demonstrates that private and semiprivate facilities alone are being taxed, with wards partly empty or with no waiting lists of significance.

Some administrators find that to give the most efficient service, the hospital should be filled to no more than 85 per cent of capacity throughout the year. Others, however, give 80 per cent as optimal for the wards, and as low as 75 per cent for semiprivate and private accommodations. Most hospitals have recently operated at a much higher figure on the private pavilions and, since this census is usually taken at 12:01 a.m., that means close to a full, or even a full, house, during much of the day. And so most hospitals have found it necessary to write rather rigid (but not inflexible) rules concerning admissions—and stick to them. Some have established priority lists based on diagnoses, giving first priority to patients with such emergency illnesses as acute appendicitis, massive burns, and acute cardiac failure; second priority to those with carcinoma requiring operation, or subacute bacterial endocarditis, and last to patients admitted for elective surgery. Other hospitals have followed other methods. None is, however, completely satisfactory, since modern medicine will tolerate but one patient to a bed at one time.

Any priority system will complicate rather than simplify matters unless it has been put on paper, is explicit, and is in the hands of the admitting office and every member of the staff (after, of course, formal approval by the medical board).

As a matter of fact, all policies relating to admissions should be in writing and might well be gotten together into a "Precedent Book."

Despite the time and extracurricular effort which must be expended in its preparation, such a book is well worth while. The material should be clearly and concisely presented with little left to the imagination and should contain at least:

1. As exact a definition of the admitting officer's responsibilities as is possible.
2. The diseases which the hospital is not prepared to admit, and the diseases which it will admit only under certain circumstances.
3. The diseases which the hospital particularly desires because of the professional interests of the staff.
4. The rôle of the admitting physician:
   - His prerogatives, his duties and his responsibilities.
   - The limits of his authority.
   - His relationships with the admitting officer.
5. The method to be used in determining the financial status of a family.
6. The criteria to be used in determining the financial eligibility of patients for ward care on a free, part-pay or full-pay basis.
7. The policy on financial arrangements.
8. The districts from which the hospital will admit private, semiprivate and ward (free, part-pay or full-pay) patients.
9. The methods of determining eligibility for care under a governmental agency, such as the municipal or state department of welfare, the Veterans Administration, the Emergency Maternity and Infant Care Program, Rehabilitation Program, funds for crippled children and others.
10. The policy on and the method of referral of patients unable to obtain admission:
    - When there are no private facilities available.
    - When there are no ward facilities available.
    - When the private patient is medically ineligible.
    - When the applicant for ward admission is medically ineligible.
    - When the applicant for ward admission is considered able to pay for private medical care.
11. As exact a definition of the admitting officer's relations to the social service department as is possible.
12. Legal aspects of admission.
13. The policy on, the legal highlights of, and the exact information required in accident cases.
14. Those items of the contracts made with the hospital which affect the admission of patients.
15. The routine of admission.
16. The policy on and the routine of night admissions.
17. The records to be kept.
18. The equipment needed in the admitting suite.
19. The rôle of the volunteer helpers in the admitting office.
20. The lists of current charges.
21. Notification of relatives.
22. Policy and routine for handling of patients' clothes.

SHOULD IMPROVE CARE

A precedent book, containing this or similar information, is written primarily for the admitting officer. It will, if used properly, reduce to a minimum the number of decisions left to the judgment of a single individual, frequently an untested appointee who might act on the whim of the moment rather than ask questions of a superior. It should aim, like everything else in the hospital, at the only goal a hospital may have: improving the care given the patient.

Its basic philosophy was described more than 700 years ago by Moses Maimonedes, the Jewish physician-philosopher at the Court of the Sultan Saladin—and by Walt Whitman, the American Poet of the Nineteenth Century.

For Maimonedes said:

"In the Sufferer let me see only the Human Being."

And Whitman wrote:

"Underneath all, individuals
"I swear nothing is good to me now that ignores individuals."

PREVENTIVE MEDICINE BEGINS IN THE HOSPITAL

SIDNEY LISWOOD
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DESPITE the fact that the functions of the hospital have been extended and enlarged in recent years, there still remain many areas in which the hospital can participate still further to improve the public health. One of these became apparent recently when the president of a large Boston corporation discussed with his physician the advisability and practicability of instituting a program whereby the executives of his organization would annually receive a thorough physical examination.

The president was anxious to furnish this service to his people and was willing to underwrite its cost. His physician, who is on the staff of Beth Israel Hospital, Boston, realized the complexity of the program and discussed with the hospital administrator the possibility of utilizing the facilities of the hospital.

Inasmuch as it has always been the policy of Beth Israel Hospital to foster better community health by means of preventive as well as therapeutic measures, the hospital promised its complete cooperation. At a series of conferences, the physician and the administrator of the hospital formulated a procedure which, by employing the diagnostic facilities and the personnel of the hospital, would most effectively carry out the program.

The first question that arose was the allocation of space. It was obvious that the present outpatient department, with its laboratory, x-ray and examining room facilities, was the most practical location in which to conduct this program. The afternoon was selected as the best time because the clinic patient load is at a minimum then and the examining cubicles are readily available.

The next problem was scheduling the visits. Consideration had to be given to the fact that a group of 72 busy executives, whose services were necessary at their place of business, was involved in the plan. It was important that the procedure be as expeditious as possible and that little time be wasted in waiting rooms. It was decided to schedule six examinations an afternoon, four afternoons each week for three weeks. Two internists were selected by the physician in charge of the program to interview the examinees and to perform the physical examination.

PREEXAMINATION QUESTIONNAIRE

NAME _____ AGE _____ ADDRESS _____

TYPE OF WORK _____

FAMILY HISTORY. Use X if any of parents, sisters, brothers, grandparents, aunts, uncles had:

CANCER	HIGH BLOOD PRESSURE	NERVOUS BREAKDOWNS
DIABETES	TUBERCULOSIS	ALLERGY
HEART TROUBLE	STOMACH ULCERS	

DO YOU FEEL WELL?

IF NOT, WHAT TROUBLES YOU?

PERSONAL HISTORY. Use X if you had:

RHEUMATIC FEVER	STOMACH ULCER	CHEST PAIN
SEVERE SORE THROATS	TUBERCULOSIS	SHORTNESS OF BREATH
DIABETES	KIDNEY TROUBLE	WEIGHT GAIN
GOUT	PERSISTENT COUGH	WEIGHT LOSS
ARTHRITIS	ALLERGY	NERVOUS DISORDER

OPERATIONS

HABITS. PLEASE RECORD DAILY AMOUNT.

CIGARETTES	PIPE TOBACCO	COFFEE
CIGARS	ALCOHOL	TEA
MEDICINES (KIND)		

RELAXATION
TYPE
TIME HOURS OF SLEEP

DIETARY. Check (S) sparingly; (M) moderately; (H) heavily; (0) none.

MILK	MEAT	ICE CREAM
FRUIT	EGGS	DESSERTS
VEGETABLES	BREAD	POTATO

FORMULATE QUESTIONNAIRE

A suite was assigned to the diagnostic clinic consisting of a waiting room and two examining rooms. The physician in charge formulated a preexamination questionnaire which was mailed to each of the examinees with instructions to answer all the questions and to bring it with him at the time of examination. Included with the form was an appointment card giving the time, the date, and the place of examination.

Each day six patients were scheduled, two arriving every 15 minutes. For example, the first two patients were given appointments for 2 p.m., the second two, for 2:15 p.m., and the third two, for 2:30 p.m. A sign placed in a conspicuous place in the lobby of the outpatient department directed the examinees to the place of examination.

Upon arriving at the examining unit, they were greeted by the nurse assigned to the clinic, who asked them

for their preexamination forms and instructed them to undress to the waist and don the gowns provided. After giving the preexamination forms to the physicians, she returned and took each patient's temperature, pulse and respiration, height and weight and gave each a visual test using the Snellen eye chart. The patient was then ushered into an examining room. By this time the two patients scheduled for 2:15 had arrived and the process was repeated.

Upon completion of the physical examination by the physician, the examinee was directed across the corridor to the laboratory, where a urine specimen and blood for a complete blood count and Kahn test were taken, after which he proceeded to the next room for an electrocardiogram.

Following the electrocardiogram, the patient was directed to the x-ray department, where a chest x-ray was done. He then returned to the dressing room, put on his street clothes and was directed to the food clinic, where the hospital nutritionist interviewed him and obtained pertinent information concerning his diet. This interview terminated his examination and he was free to leave. On the average, the patient spent from an hour to an hour and a half at the hospital.

Upon completion of all the examinations, the data were assembled and the physician in charge of the program summarized the findings and recommendations. He then scheduled an interview with each of the examinees through the personnel office of the organization. These interviews took place in an office convenient to the front door of the hospital and were scheduled for the late afternoon in order not to interfere with the working hours of the patients. The physician reviewed the findings with the patient and made recommendations regarding after-care. If any condition was discovered that required further medical attention, the patient was referred to his private physician.

Upon coming to the diagnostic clinic, each patient was given a unit serial number. His record then became an integral part of the hospital unit record system. The completed records, however, are kept in a separate file labeled with the name of the organization, and a "dummy" showing the location of the record is kept in the hospital master file.

It may be of interest to know that several cases with incipient serious medical implication were discovered during these routine examinations. The organization which instituted the program has expressed extreme satisfaction with the results.

The program as outlined extends the functions of the hospital into the area of preventive medicine and enhances the rôle of the hospital as the health center of the community.

THE VALUE OF PHYSICAL THERAPY in the Small Hospital

ALMA M. TROXELL

Superintendent, Oil City Hospital, Oil City, Pa.

A SMALL hospital is always confronted with the problem, "Should we or should we not establish a physical therapy department?" When the 155 bed Oil City Hospital was opened in 1929 its administration pioneered in the installation of a well planned, completely equipped physical therapy department. The establishing of this department was indeed a new adventure in medicine in our community, but during 19 years of operation the project has proved its worth by rendering invaluable service to our patients and doctors.

The first step to be taken in initiating a physical therapy department is the planning of an educational program designed to arouse the interest of the doctors. The growth of the department is dependent upon their constant use of its facilities and it is, therefore, imperative that they be made fully aware of the benefits to be derived from the installation of such a feature. At the present time many doctors who served in World War II have received practical training in the use of physical therapy and, as a result, are fully informed of its value, so that their enthusiastic approval can be readily obtained and the introduction of this service can be a comparatively simple matter.

In our hospital the physical therapy department is located on the ground floor, where it is readily accessible to ambulatory patients. It is conveniently near the elevators so that transportation of hospitalized patients, either in beds or in wheel chairs, is a simple procedure.

In order to provide space for an additional patient unit the department was completely reorganized during the last year, although it still remains on the ground floor. An architect was employed to draw up the plan, as shown here. Every effort was made to keep the department attractive and yet provide the utmost possible privacy for patients.

The walls are painted a soft blue-green, giving an appearance of coolness. Cubicle curtains of peach-colored material slide on chrome rods. The hydrotherapy and colonic rooms are attractively done with pale green tile walls and gray-green tile block floors. Fluorescent lighting fixtures are used throughout the department.

The type of treatments used in the department are:

Thermotherapy

Short wave diathermy
Conventional diathermy
Heat cabinet
Electric baker
Hot water bottle
Hot water spray
Moist heat (hot fomentations)
Hot packs
Hot paraffin baths

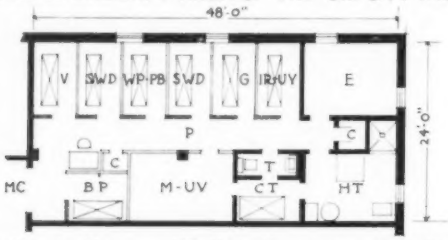
Hydrotherapy

Spray and douches
Colonic irrigations
Local packs and compresses
Whirlpool baths

Electrotherapy

Mecholyl
Galvanic current

PHYSICAL THERAPY AREA OF THE OIL CITY HOSPITAL-OIL CITY, PA.



MC - Main Corridor
B P - Bed Patients
M-UV - Massage-Ultra-V.
CT - Colonic Treatment
T - Toilet
HT - Hydrotherapy
P - Passage
C - Storage Closets
V - Vascular Suction and Pressure
SWD - Short Wv. Diathermy
WP-PB - Whirlpool-Paraffin Bth.
G - Galvanic Treatment
IR-UV - Infra-Red-Ultra-Violet
E - Exercise Therapy

Sinusoidal current
Vascular suction and pressure
Surface pyrometer (skin temperature)

Mechanotherapy

Massage
Corrective exercise

Light Therapy

Quartz lamp, water cooled
Quartz lamp, air cooled
Infra-red light

The exercise room contains a stationary bicycle, a wheel for shoulder exercise, a chest weight, a stall bar for hand exercise, and a ladder for finger exercise. The last four items can be made in the hospital workshop. A discarded typewriter provides an excellent means of finger exercise.

While good equipment is essential, it alone does not make a physical therapy department. The success of our department is due to the efforts of a well trained physical therapist under the direction of a member of our medical staff. We also have one technician who has been fully trained in the department.

The appointment of a physical therapist is of major importance if the department is to be successful. Individual reaction to this type of treatment may be variable, so that experience, judgment and high sense of responsibility are essential qualities in the physical therapist in order that she may inspire the confidence of the patient. Moreover, a professional attitude and a well developed personality are as necessary for the physical therapist as they are for the doctor or the nurse.

The department is open daily from 8:30 a.m. to 5 p.m., except Saturday afternoons and Sundays, when emergency treatments only are given.

Patients treated are referred by a physician who orders the type of treatment the patient is to be given. A record is kept of all treatments. A record of treatments given a hospitalized patient is filed with the chart.

There are two basic charges: one price for single treatments and one for any combination of modalities. All collections are made by the general business office.

The main expenses of the department are the salaries of the technicians. Expenses for laundry, repairs and supplies are kept at a minimum. Minor repairs are done by the maintenance department. Since January 1930, no month has shown a deficit. In 1930, the first year of operation, 2763 treatments were given to 270 patients as compared with 3432 treatments administered to 308 patients during 1948. This averages about 10 treatments per patient, which is reasonable for a course of treatments. (We believe that the determining of this average is an excellent means of assuring doctors and patients that the treatments are not being prolonged unnecessarily.) As stated previously, it is most important to have the cooperation of both the medical and surgical staffs for the continued growth of the department. We are fortunate in having the cooperation of approximately 90 per cent of our staff members. We feel that from time to time reports of medical histories combined with the results of physical therapy treatments should be given at staff conferences, and we have found these an excellent means of educating those doctors who are not using the physical therapy facilities. It is also most helpful in stimulating the interest of any doctors who are not entirely familiar with the services available.

What is the value of a physical therapy department in a small hospital?

Experience has shown that the length of stay in the hospital can be shortened and suffering can be substantially relieved by these methods of treatment, thereby improving patient morale.

The therapeutic value of the department has been established in our hospital to the extent that its services are being used by every department, with a yearly increase in the number of outpatient treatments. At present 50 per cent of the patients are outpatients.

In our community the public is being educated to come to the physical therapy department of the hospital; consequently, this keeps the patient under the care of the medical profession and provides adequate follow-up of each case.

From our experience I am convinced that physical medicine is not only a valuable but also a necessary adjunct to the modern hospital, whether it is large or small.

WRITE FOR YOUR VOLUME INDEX

If you bind your volumes of The MODERN HOSPITAL you will want the index to volume 72, covering issues from January through June 1949. You may obtain your free copy by writing to The MODERN HOSPITAL at 919 North Michigan Avenue, Chicago 11, Illinois.

LICENSURE

Works for the Hospital

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MORE and better health services for all people is a vital motivating factor in public health programs, in the national hospital program, in health educational plans. The problems, specific objectives, and methods used in attaining health goals are many and complex. Hospital licensure is often a misunderstood subject among these complexities. Licensing, potentially at least, is one of the most useful tools available in attaining the goal of an efficient and adequate standard of patient care. Progress toward this goal will be proportionate to the vision, understanding and cooperation of leaders in the hospital field through the intelligent interpretation and application of the sound fundamentals of a good licensure program.

Unfortunately, the term "licensure" has a connotation which is objectionable to some people. This feeling is frequently more pronounced in the case of professional people who are justly proud of their codes of ethics. As a result, additional regulations are sometimes resisted, either actively or passively, on the basis that they are unnecessary and not for the best interests of the professions concerned.

LICENSURE IS DESIRABLE

It is the general consensus that hospital licensure is desirable as evidenced by the leadership and active support of the American Hospital Association in the passage of hospital licensure laws throughout the country. It would appear in many instances that the benefits of licensure have not been adequately evaluated to show the concrete benefits that accrue to the hospitals. Therefore, a clear understanding by everyone concerned is necessary in order to gain the support that is essential for full development of the licensure program. Without this support, the program will be sterile and incapable of bearing fruit to the advantage of the individual hospitals.

Let us examine, for a moment, the purpose of hospital licensure as stated in the model hospital licensing act recommended by the Council of State Governments and other interested associations and groups. This model has been used by many states as a guide in the drafting of licensure laws. Section 2, Purpose, reads "The purpose of this Act is to provide for the development, establishment and enforcement of standards (1) for the care and treatment of individuals in hospitals and (2) for the construction, maintenance and operation of hospitals, which, in the light of advancing knowledge, will promote safe and adequate treatment of such individuals in hospitals."

Stated simply, licensure is designed to improve patient care in hospitals. There is nothing new or startling in this statement. Those individuals who have chosen a career in hospitals usually have not done so for the purpose of personal gain and aggrandizement. There are surely pleasanter fields from the standpoint of financial return and hours of work but probably none in which there is greater personal satisfaction. It is gratifying to note that the countrywide pattern of hospital licensure is predicated upon the rendering of a service to the hospitals so they can better discharge their responsibilities to the patient and community.

The background of experience in the over-all licensure program is rather limited, making it difficult to state categorically just how the program can best be carried on and what specific benefits may be derived from it. For a number of years many states have carried on a licensure program for maternity hospitals and homes. The standards and regulations developed for these programs were concerned chiefly with the maternity service and features of the physical plant. While some appreciable advances have been made, the programs were limited in scope when viewed in the light of what is today considered to be an adequate hospital licensure program. It is only within the past several years that some states have extended their licensing laws to encompass the general and special hospitals, together with such related institutions as nursing, chronic and convalescent homes.

AN EDUCATIONAL TOOL

In most states emphasis is properly placed on the use of the regulations as an educational tool rather than the arbitrary exercise of state authority. In the case of related licensure programs, they have been most effective when the public and the administrators of the activities being regulated had an understanding and desire for the benefits of regulations. It is clearly evident that the licensure programs have not been initiated as a means to develop a new source of revenue for the respective states. In those instances where a licensure fee is being levied, the income is in no way adequate to support the program. The chief advantage attributed to a fee for license is that it tends to attach a somewhat greater significance to the license.

It should be realized that licensure laws impose limitations on both the establishment being regulated and the administering authority. This feature

in itself is a safeguard in that the legal rights of hospitals are carefully balanced against the enforcement power of the licensing agency. A common provision of all these licensure laws includes the creation of an advisory council for the joint development of the minimum rules and regulations under which hospitals will qualify for a license.

This advisory group, composed of individuals particularly qualified in various fields of hospital maintenance and operation, should be competent to develop, with the state agency, policies affecting the administration of the law and the development of a hospital program keyed to the needs of the hospitals in the state. When the group subject to regulation is given this voice in the program, there is not too much to fear from the standpoint of unreasonable standards or enforcement procedures.

In reviewing the standards of maintenance and operation for hospitals as included in the various state plans, it is evident that no one set of standards would be satisfactory for all states because of the diverse problems in the different states. It is a well recognized fact that the standards as adopted are not static but will be improved as the program continues.

SOME WILL BE CLOSED

There has been some feeling expressed that a strict enforcement of standards will result in closing many hospitals. With the present need for hospital beds, any such action would be subject to serious question. Some hospitals will be closed and should have been long ago. Many will go through a period of self-improvement to meet the requirements. It must be realized that hospitals which do not meet certain minimum levels of facilities, technics and procedures must initiate action to correct those features in which they are deficient in order to provide safe patient care. The enforcement agency through a survey can outline a continuing program for improvements and corrections, with the most critical items receiving first attention.

It would not be reasonable to assume that all hospitals in the state can comply with the standards immediately. The important point is that continuing progress toward compliance will be made. In other certification and licensure programs the expedient of a temporary or provisional certification or license with a specific time limit has been used to good advantage. Improvements to the physical plant may require several months, or limitation of funds may delay the correction. At the expiration of the time limit, a review of what has been accomplished may justify the extension of the provisional license as long as patient safety is not jeopardized.

When a real effort is made to comply with the standards and where patient safety is ensured, no serious criticism should be leveled at the institution. Only when such an effort is not made and when the physical plant is entirely inadequate will it be necessary to resort to enforcement to obtain improvement. This will certainly be unusual inasmuch as the need for compliance with the minimum standards will be self-evident to all those concerned.

BENEFITS TO BE DERIVED

What are the benefits which the individual hospital may expect from a well rounded hospital licensure program? The first comes from an unbiased survey of the procedures, technics and facilities of the hospital. All too frequently close association with one institution results in tolerance or even neglect of undesirable conditions because of the limited perspective and lack of comparative standards. The competent hospital surveyor is in a position to furnish an unbiased service, and in consequence improvements in efficiency may result from minor changes in technic and procedure. Not infrequently the recommendations made by the surveyor are particularly helpful in relieving hospital administrative personnel from the onerous task of imposing what some employes may construe as whims and fancies on the hospital staff. This device, however, should not be abused by hospitals since the actual administrative responsibility is that of the hospital and not the licensing agency.

Specialized consultative service on special problems is a real benefit to any hospital. In many cases these problems will be beyond the provisions of the licensing regulations. The state agency will have available the services of specialists in various fields —medical, nursing, engineering, dietetics, pharmaceutical and laboratory— whose help and assistance will be available to the individual hospital.

In addition, the licensing agency can function as a clearinghouse for the dissemination of information through the distribution of printed material, through the holding of institutes, probably in cooperation with the state hospital association, and through general conferences with the hospital staff following surveys or upon request of individual hospitals. Both the licensee and the licensing agency benefit from this educational approach.

One real benefit which is frequently overlooked is the protection afforded to the licensed institution against unfounded and unjust criticism. There is no better way to combat such attacks than to be able to present evidence in the form of the license that the minimum standards of maintenance and operation are being observed. The license posted in the hospital provides a degree of assurance to the public that it is receiving the protection to which it is entitled. Through public demand the grading and posting of restaurants were accomplished. Surely, the public should be just as interested in knowing the status of hospitals.

SURVEYS SHOULD BE USEFUL

Surveys made by the licensing agency can be extremely useful to the administrator in bringing to the attention of his governing board the need for various improvements. Again, unbiased surveys resulting in specific recommendations for changes in facilities, technics or procedures may carry more weight than would the recommendation of the staff.

In the broader phases of the hospital program, it will be possible to ensure public recognition of specific needs of the hospitals in the community. Are more beds needed? Are the adjunct facilities adequate? These are only two of the questions that may be answered. With the awakening of the public to the part that hospitals play in daily life, primarily as a result of the increasing acceptance of group hospitalization prepayment plans, the recognition of the need will be a long step toward the ultimate satisfaction of that need. The other side of this problem, *i.e.* the evaluation as to how the hospital can best serve the needs of the community, is equally important and will be pointed up by the licensure program.

Finally, those of us in health agencies are hopeful that the licensure program may help to coordinate positive efforts toward total health care for a healthier community of people —ourselves!

People in Pictures



Most Rev. William T. Mulloy, Catholic bishop of Covington, Ky., turns the first shovelful of earth at ground-breaking ceremonies held in March to inaugurate the development program of St. Elizabeth Hospital. The entire development will cost between $1,300,000 and $1,400,000; one-third of the construction cost will be financed by a federal grant and the remaining two-thirds, by the Sisters of the Poor of St. Francis.



Representatives of management, labor and the insurance field meet in New York City to discuss a comprehensive welfare program, including Blue Cross and Blue Shield protection for 1800 iron and structural steel workers.

Dr. Edward M. Bernecker (second from right) examines a certificate presented to him by the Greater New York Hospital Association. Left to right: Louis Schenkweiler, Hon. William O'Dwyer, mayor of New York City, Dr. Bernecker, and Dr. Marcus Kogel, new commissioner of hospitals.





Julia Weiner, 19, a patient at St. Vincent's Hospital, New York City, is the two millionth person to receive hospitalization benefits from New York's Blue Cross plan. She is visited by Francis Cardinal Spellman, Sister Loretto Bernard, superintendent of the institution, and other notables.

Spring graduates from the postgraduate schools at St. John's Hospital, Springfield, Ill., seated (l. to r.): Sister M. Michaelene, P.H.J.C., pediatric nursing; Sister M. Ildephonsa, Felician, obstetric nursing; Sister M. Roseanne, operating room technic; standing (l. to r.): Doreen Alleman, pediatric nursing; Mary Curran, obstetric nursing, and Margaret Dowling, operating room technic.





Photograph by William Rittase. Courtesy, Somerset Hospital, N.J.

This infant has been promoted from incubator to bassinet.

A "PREEMIE'S" PROGRESS DEPENDS UPON GOOD NURSING CARE

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WAITING in the corridor of a metropolitan hospital, a young man is pacing the floor, anxiously waiting for news of his wife, who is having a baby. A nurse approaches to speak to the expectant father saying, "Mr. Johnson, it's a baby boy. It is small, only 4 pounds, but both your wife and baby are doing well."

Hearing this, Mr. Johnson looks at the nurse worriedly and asks, "Four pounds is awfully little for a baby, especially a boy. Will everything be all right?"

The nurse smiles, explaining that because of new technics being used especially for the care of premature infants, the child has a perfectly good chance to survive.

"With the special care that is given to premature babies, such as the secure, even warmth of an incubator, the adequacy of a prepared diet, and the constant vigil of a staff of nurses, trained especially in caring for the premature infant, your baby can attain regular weight in a few months. It all depends on his progress," the nurse cheerfully assures Mr. Johnson.

Such have been the advances in the care of "preemies" (as the infants are called), that within the space of 10 years the death rate among these babies has dropped tremendously wherever proper methods of care have been adopted. In almost half of the states, some work is being done to decrease the mortality rate among prematures.

A four-week course for nurses at Wayne University in Detroit is teaching the principles of care of premature babies. It is one of the first courses set up as a staff education project for nurses within a state to provide experience and theory for those nurses in small hospitals in which few premature infants are born.

In this course, sponsored by the university in cooperation with the Michigan Department of Health and numerous Detroit hospitals, the students will observe and have experience in the basic technics of this highly specialized nursing field.

Most nurses have already had some instruction on care of premature infants during their regular basic training. The Wayne course supplements this basic training with instruction and experience in the areas of establishing respirations, controlling temperatures, feeding, prevention of infection, and parent education.

The course is financed in part by a grant from the U.S. Children's Bureau through the state health department. Only graduate nurses are admitted and they spend a 40 hour, five-day week in their work, with division of time to allow classroom study as well as actual hospital experience.

All of the Wayne students are graduates of recognized schools of nursing. Some of them are heads of obstetric and pediatric wards in small town hospitals, where adequate facilities for learning new technics are lacking; others are nurses of considerable experience with "preemies" who are using the course as a refresher.

The course is limited to six students at one time because adequate facilities for actual nursery experience are limited. Students have practical experience in three of Detroit's hospitals, Providence, Herman Kiefer and Woman's, each of which has a premature infant nursery. In these hospi-

tals, students learn practical application of the theories they have learned from lectures beforehand. They work with nurses who have had years of experience.

Care given premature babies has been almost standardized in many hospitals, but new methods of care are constantly being utilized to lessen the death rate. The course at Wayne covers the care of the delicate babies from birth until the time they are able to get along with only the normal amount of maternal attention.

From the day Tommy (the Johnsons' baby) makes his way into the world, practically as red as the well known beet and with as many wrinkles as an old philosopher, he is tended with the utmost care by a staff of nurses who watch attentively for any sign of breathing irregularity, infection or unusual behavior.

At birth, Tommy, with his veins protruding noticeably from his thin and pliable skin, is unable to maintain his proper body temperature and consequently must be put in some sort of a device capable of keeping it at around 88° F. with a humidity of 60 to 70 per cent. The necessity for special warming apparatus for prematures has long been recognized. J. Bartlett, an American, after making a report on various types of incubators then in use in France and Russia, invented in 1887 what he called a "waterjacket warming crib," which we recognize today as the first practical incubator.

HAVE MANY REFINEMENTS

Today, incubators have many refinements. Tommy's feeding, for instance, may be accomplished through armholes in the side of the incubator, so that temperature is constant. Tube feeding may be used at first as the infant has not the strength to suck or swallow his food. Some feel that mother's milk is the most healthful food. Usually it is taken from a "mother's milk bank" maintained in a hospital. In Detroit, Woman's Hospital has maintained a mother's milk bureau for 34 years.

When Tommy is about 10 days old, he is introduced to vitamins A, B, C and D. At the age of three to four weeks, doses of iron are added to the diet to prevent anemia.

An accurate record is kept of Tommy's progress, so that transfusions and other treatments can be given if necessary. Because there is such a slight increase in weight for the first weeks, scales register the weight in grams. The weight shows accurately the progress the infant is making.

Bathing the baby takes place when his condition warrants it. Until that time he can only be cleansed with oil. This cleansing must be done carefully and gently as the premature is highly susceptible to any sort of infection. Epidemics of diarrhea and impetigo are easily started in a premature ward and steps must be taken for their prevention.

While all of these modern technics of care have been applied to little Tommy Johnson, the parents have been able to follow, in general, what has been done for him. They have frequently visited the hospital, and, watching procedures through the premature ward's large window, have seen the baby fed, bathed and weighed.

Now Tommy is one month old, weighs five pounds, and is getting ready for a big event in his life's history. He has already been moved out of the incubator to a bassinet. He now goes into a "discharge nursery" where he has a chance to meet his parents for the first time, without any troublesome pane of glass between them.

The discharge room is important. It is the training ground, where Mr. and Mrs. Johnson can learn how to care for Tommy under the supervision of the same nurses who have cared for him up to this point.

With Tommy in her arms, Mrs. Johnson is a little fluttery.

"Am I holding him all right? Is there danger from my breathing in his face?" she asks.

The nurse reassures her, showing her how to cuddle Tommy a little more gently.

On the next trip, by prearrangement, Mrs. Johnson actually bathes Tommy; and although she comes through the experience a little breathlessly, she feels new confidence when she gets through.

After a few days, Mrs. Johnson has been given enough information and has had enough actual experience so that she feels no fears at all when Tommy, bundled up, is handed to her and Mr. Johnson for his trip home.

Mr. Johnson, himself, has learned enough so that Tommy is no stranger to him and he knows that he can give him care, too—when it's necessary.

As a matter of fact, Tommy is now approaching the point where he can be treated almost as a normal baby. But the precautions his parents have learned will reinforce his chances of normality and good growth.

The situation for Tommy and his parents is considerably better than it might have been years ago, not only from the standpoint of scientific technics but from the social standpoint as well. In Colonial America, under the strict, sometimes harsh, Puritan rule a mother giving birth to a premature child was considered a sinner by the community and was severely punished.

There are a number of causes of premature birth of a child, the chief one being lack of prenatal care. Improper nutrition is also known to cause prematurity. Therefore, there is a much greater percentage of premature births among persons who cannot afford the diet which is needed for normal embryonic development. Doctors are stressing especially the fact that cases of prematurity can be diminished, if not almost completely done away with in time, through adequate diet and good prenatal care.

Accidents are also a cause of prematurity. Often, after a mother has been subjected to the jar and shock of a minor accident, premature birth will take place without any injury or disfigurement of the baby.

NO CRITERION FOR FAILURE

Prematurity is not a criterion for failure to develop later in life. There is absolutely no basis for the thought held by some that premature babies develop into thin, undernourished or less intelligent individuals than normal babies.

Approximately five out of every 100 babies are born prematurely so premature nurseries have a fairly constant flow of new babies to tend. The need for premature care is determined not so much by the month in which the baby is born as it is by his weight. Hence, a baby born in the ninth month but weighing less than 5½ pounds, (the standard division between premature infants and normal babies), is called premature.

Courses similar to the one being taught at Wayne are constantly improving the care given to premature infants and thereby removing some of the fears which were formerly attached to having a premature baby. The security fostered by such programs is a boon to all the Mr. and Mrs. Johnsons of today. They can rest assured that adequate care minimizes the risks their baby ran through putting in an early appearance.

HELPFUL HINTS FOR THE RECORD LIBRARIAN

NOT long ago when I was reading an article on the high cost of living I came across the words "controlled economy" a number of times. I began to wonder: If "controlled economy" is the answer in the business world why isn't it the answer in other fields? Anyone who works in a hospital is acutely aware of the financial problems; perhaps this is a solution.

Although the medical record librarian is not under the pressure that other department heads, such as the purchasing agent, housekeeper and dietitian, are, still she, too, must assume some of the burden of keeping costs down.

Now by controlled economy, I do not mean to avoid buying the necessary equipment or to use material that increases the time required to accomplish the work, but I do mean a careful working out of the essentials that bring results and save money for the hospital. Economy in this sense consists of the budgeting of equipment and time as well as materials. As one writer put it, "A budget is a tool of management and is only as effective as the hand that wields it."[1]

ASSUME SHE IS TRAINED

We are assuming that the record librarian is trained for her work, knows her department, her hospital, and her medical staff. Does she have enough help to carry on the work effectively? No department head, however well prepared for the job, can carry on with too heavy a load and do it well.

The records of an institution of less than 40 beds can be handled by one person; in a 40 to 70 bed hospital there is need for a full-time record librarian with at least a part-time helper; a record librarian and two or more full-time assistants are needed in the hospital of more than 70 beds.[2]

The first thing to consider in this program is the economy of equipment. We are advised to have a room large enough to have plenty of working space and adequate lighting. We agree, but in many of the old hospital buildings, or in small institutions, any room must be acceptable, whether it was once a pharmacy with bars on the window, a room where they used to bring patients about to die, or an old sunporch. Whatever type it is, it should be attractive. The walls can be painted in pastel colors and kept clean. A good floor saves backaches, shoe leather, and costly repairs.

The furniture, if it is secondhand or the castoff from another department, can be cleaned and repaired. There should be tables, a comfortable chair or two, plenty of ink, pens, ash trays and scratch-pads for the doctors. When there is no room for tables, shelves can be constructed against the wall in such a way that they will serve as writing desks for interns and doctors.

The desks should be large enough, and the typewriters should be of sufficient number to keep the routine work progressing unhindered. Electric typewriters afford a great saving in time and fatigue. Secondhand typewriters should not be purchased, however; the loss of money every time they need repairs more than overbalances the initial saving.

If the budget allows for a dictating machine or two, they should be installed. However, the type of machines purchased should be carefully considered, for what may work in one institution will be worthless in another.

Filing cabinets for the most recent charts are second only in importance to adequate space for records. Both the open steel shelving and steel cabinet files have advantages. Shelving can be arranged in double stacks from floor to ceiling, with divisions every 2 feet.[3]

Steel cabinets, if used, should be in good condition. It is poor economy to purchase cheap ones or a variety of types and sizes. They are used too much to risk the waste of time and labor expended in trying to open, close or push the drawers that "don't always work." The five-drawer filing case occupies 25 per cent less floor space than does the four-drawer size and is less than a half a drawer taller. This is a convenient working height even for the worker of less than average height.

Where space is a great factor, these files can be placed on top of each other the full height of the wall, thereby making use of that large space that usually exists. Of course, a sturdy ladder is necessary, and if it is possible to obtain one with large casters and a trolley ceiling rail between stacks, so much the better. To help fill the large spaces between the stacks, a cabinet that "rocks" open sideways is sometimes used.

In addition to filing space for current records, there is the eternal cry for space for the preservation of old charts. Storage rooms may be found anywhere from attic to basement or in adjoining buildings. Everything has been used—from a discarded coal bin to an old rabbit hutch, or to a room directly beneath the record office. This casts no reflections on anyone. The administrator would be only too happy to let the librarian use the room next door to the record library, if he could, but hospitals aren't built that way. To offset the time spent in traveling to and from the storeroom, the furnishings within the room should be arranged so as to save as much time as possible in searching for charts.

PERMIT TRANSFER OF FILES

Some hospitals use old files in the record room. They take extra space, are usually crooked, the drawers stick, or something else is wrong; otherwise they wouldn't be discarded. They do, however, have one good feature. Besides keeping the charts clean, they permit the transfer from one place to another to be easily accomplished.

Strong cardboard boxes can be purchased. They are so constructed that charts can be placed vertically in them. Each box holds about 50 charts of average size, and on the front of the box can be inserted or pasted the numbers of the first and last charts. There is much to be said for this method of storage. The boxes are not expensive and can be made up when needed. They can be stacked or placed on shelves and are easily accessible.

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Library stacks of steel or wood shelving, with divisions about every 2 feet, on which the charts can be filed edgewise like books, are often used. These cost very little, store the largest number of medical records, and are accessible. They have the disadvantages of not keeping the charts clean and of creating some difficulty in removal and reinsertion of a record.

Microphotography is the most recent method of caring for old charts. There are arguments for and against this process.[4] Many administrators cannot be won over to the use of it because of the cost. A talking point which may be used in favor of the installation of microfilming equipment is that it need not be confined to the record department but can be used for the bookkeeping office, nursing school records, dietetic reports, and so forth, and one viewing box can be made to serve all of them if the hospital is a small one.

GRADE OF PAPER IMPORTANT

Paper is a constant expense to a hospital. The grade that is used is a big factor in carrying on an efficient department. If certain forms or reports are not to be preserved for a long period, the lasting quality of the paper need not be considered. If the sheet is to be kept permanently, only the best should be used. If, however, the record is to be microfilmed, the quality of the paper selected should be determined by whether a pen, pencil or typewriter will be used.

The matter of filing space may determine the type to be used. A 20 pound stock has three-fourths more thickness than has the 16 pound sheet. This means that 250 sheets per filing inch of the 20 pound stock would be used as compared with 333 sheets per inch of the 16 pound. This same principle holds in card filing.[5]

New forms are coming on the market on which several types of services, such as the anesthesia record and operative report, can be combined for use in the smaller hospital. On certain obstetrical records used in nonteaching hospitals some sections are condensed and others are eliminated. If a record librarian has a duplicating machine at her disposal, she can work out several forms, run them off on the machine, and then have the one found to be most satisfactory printed. It is interesting to note how much easier it is to get doctors to fill out forms if all the questions are on one sheet instead of two or three.

The folders or envelopes used for holding charts are often purchased in a rather hit and miss fashion. These, like the material on which the chart is printed, should be durable. Whether the folders or the envelopes are used, the same point must be considered. The wood pulp of northern pine is said to make the best paper and has the longest life.[6]

Every record department needs various indexes to maintain its efficiency. The four most used are the patients', operative, disease and physicians'. The system used for keeping these is the choice of the record librarian, the administrator, and the medical staff, but it is the record librarian who can tell which method is the most advantageous to her hospital.

If there is plenty of room, the visible or vertical index equipment is excellent, but if space and money are limited, looseleaf notebooks are a good substitute. It is well to know the medical staff needs as to whether it is wiser to order a form put out by some record company or to make one especially for the hospital. Here, the duplicating machine may come in handy. The sheets do not look so nice as do the printed forms, but in hospitals where the demand is limited they are much cheaper to use. In small hospitals where doctors do little or no research, only the most essential points need be indexed. It has been proved many times that disinterested doctors have become interested in a simple system in a notebook while a more elaborate setup bores them.

The next point in this program of controlled economy is that of time. Have you ever noticed how much time is wasted because of the inconvenient location of the office furniture, poor organization of the material at hand, and lack of coordination with other departments? Regardless of the shape of the room, the desks and tables should be placed to the best advantage.[7] A desk near the door saves steps when the record librarian is on the watch for doctors or must deal with people who come in. A telephone should be within easy reach; in fact, if there is more than one worker in an office, two or more telephones are no luxury. Time and motion study experts say that too much time and energy are consumed by the average worker in just reaching for the telephone or having to walk across the room to answer it.

If one receives many inquiries as to patients' addresses, ages and so forth, the card file should be readily accessible and should be broken down in several sections with auxiliary guides.

All materials should be placed as close to the worker as possible. The height of the desk, table and chair should be arranged so that alternate sitting and standing at work are possible without effort. The chair should fit the body of the worker. This increases the speed of work and reduces fatigue. One hospital librarian acquired a metal desk and chair of which she was very proud and which she enjoyed using. Within a short time she began to have backaches and soreness in the calf muscles. About the middle of the day, she began to become weary.

STRAIN ON BACK

A salesman came in to see her one day and during the conversation, she spoke about this condition. He told her the trouble. She was of less than average height and the desk was just high enough so that she had to rest her elbows on the top in order to write. The chair was not suited to her; her feet never reached the floor except when she sat at the edge, thus causing a constant strain on the back and thigh muscles. As the desk could not be changed, a platform was built to fit the open space in front of her chair on which she could rest her feet. The pain and tired feeling disappeared, more work was accomplished, and there was no increased expense.

There should be adequate lighting in the office and the storage room and a generous window area with metal venetian blinds to control the light. If this isn't possible a good type of artificial lighting should be demanded, for without it fatigue and eyestrain result.

There are many small inexpensive gadgets which are invaluable to record keepers. A bulletin board can hold items of interest and it is one way of getting doctors into the office to finish up charts. It also cuts down on the answering of questions.

An alphabetical expanding file the size of a portfolio has been helpful to one record librarian who has to keep operative reports, consultation sheets, and other reports to be signed. She carries these about with her on her rounds and whenever she meets a doctor whose signature she wants, she quickly withdraws the sheet and he signs it, using the folder as a desk top.

Another record librarian uses the file for laboratory reports that come in after the patients have been discharged. They are kept here in alphabetical order until time is available to put them on the charts.

DOCTORS CAN FIND THEM

When doctors want carbon copies of reports, if there is no drawer space available, the expanding portfolio can be used for this purpose. It can be placed on a certain shelf and the doctors soon learn to recognize it and help themselves without bothering the office force.

When the medical record department fills in the Blue Cross diagnoses and other insurance forms with the business office, a heavy envelope folder is very satisfactory for transferring them from one office to another.

Card files can be used for a multitude of things, such as case numbers for incomplete histories, addresses for insurance companies, changes to be made on charts, and telephone numbers. If the hospital budget does not allow for a file, and you do not wish to purchase one yourself, ask the stationer for a box in which he buys index cards of the size you think you need. You can place a smaller box inside for a block to hold the cards erect. This has the advantage that by the time you have proved that a permanent file is a necessity you have learned the type and size that will best serve your purposes.[5]

When a large number of charts must be filed away each day, various devices can be used to save steps. One librarian has a small table on casters. It is about the size of a bedside table; upon it is nailed a box. It is easy to push about and she wheels it to whatever drawer she wishes to use. In this way there is less danger of filing the wrong charts, footwork and stooping are reduced to a minimum, and the job is completed in about half the regular time.

Small notebooks, both looseleaf and bound, are helpful. They are a saving in drawer space and can keep almost any type of daily information needed. Ledger books often serve where large reports are not necessary. In several small hospitals, they serve as the numerical index of admissions.

Every record librarian needs books in her office. At least one book should be purchased a year. If the hospital does not feel it can afford to do this, the record librarian should buy them and build her own library. It is almost impossible to run a medical record department without a medical dictionary, a "Grey's Anatomy," and a large dictionary. It is difficult for some hospitals to purchase them, for the outlay of money seems heavy, especially when the hospital is small and the school of nursing requires so many. A fairly good substitute is a nursing textbook on anatomy and a small medical dictionary. The director of nurses will gladly give you copies that are no longer in use.

CAN BUILD A CABINET

Some medical record rooms have closets or special places in which stationery and other materials are kept readily accessible between the times when requisitions are sent to the stockroom; others are not so fortunate. If the latter is the case, other means must be devised for economy of time and shoe leather. File drawers may be used, but this is a sacrifice of good chart holding space. A wood cabinet, much like those used in home kitchens for brooms and mops, may serve well in small hospitals. The carpenter can put in a few shelves, the painter can apply a coat of wall matching paint, and the miniature storeroom is complete.

Do not discard the boxes in which the chart folders are kept; they make excellent storage boxes for every department. They are large enough to hold stationery yet small enough to fit into a locker or cabinet. They can be arranged neatly with labels pasted on the front or side so that one can tell the contents at a glance.

Another item in the controlled economy planning is that of arrangement of materials in and on the desks. As one superintendent expressed it, "The record library is usually a beehive of activity, but there is little excuse for its looking as though it had been struck by a miniature atomic bomb."[9]

Have you ever stood beside someone who was looking for something in her desk and watched her go through one drawer after another pushing about antiquated papers, dusty boxes, every kind of debris, from gloves to boots, to find what she wanted? It is just as essential that the desk be well organized as it is that the department be run efficiently. A wire basket or spindle can hold the requests until it is time to consider them. Everything should have a place so that the precious minutes need not be lost in the looking. Why not take a few minutes off twice a day and clear the desk top of everything but the materials you need at the time? If this seems difficult, help in organization may be obtained through various work analysis tests.[10]

As yet, there is no sure way to economize on time, energy or money in getting charts completed. All kinds of devices have been used, but as has been stated before, the record librarian must know the institution and doctors before inaugurating some plan that succeeds. She must use her God-given imagination and work out her own solution.

It is not possible to touch on all the items of economy but there is one final point to be made in this connection. No amount of planning, however well done, will accomplish anything unless it is put into effect. There is little gained from planning for the planning's sake; it is a good sedative but should not be taken too often. Even if the money can be stretched to accomplish only one or two things at a time, do not get discouraged. Keep on planning and keep on working.

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HOSPITALS NEED MORE INSURANCE

Survey shows many small hospitals have only token protection

FIRE and liability insurance coverage in small hospitals varies all the way from full protection to "token insurance" that must be considered inadequate, a small hospital forum on the subject of insurance would indicate. Sixteen hospitals were included in the survey; they ranged from 30 to 100 beds and were located in rural areas or small towns in all sections of the country.

The most nearly complete fire coverage was in a hospital of 100 beds which has slightly less than $1,000,000 in fire insurance. While the value of the insured plant was not stated, insurance coverages ranging down to $50,000 or less in some of the smaller hospitals—in many cases as little as $1000 per bed, can scarcely be considered adequate, even in the most antiquated plants, in view of construction costs that average $15,000 a bed today.

Only a few of the respondent hospitals indicated that they have increased their insurance coverage to keep abreast of rising property values in recent years. Six hospitals in this group have made no change in the value of their insurance in the last five years. An additional six hospitals have increased the amount of their insurance by 50 per cent or less in this period. Two hospitals have doubled the amount of insurance they carry and one reported an increase of nearly 200 per cent.

About one-third of these hospitals carry burglary insurance against loss through office robbery, messengers and similar minor risks. A few hospitals indicated that fire insurance policies included sprinkler damage and other attendant losses and several hospitals carry separate insurance against loss due to wind storm and tornado.

Hospital liability and malpractice insurance is carried by all but four hospitals in the group. Limits vary from $5000 and $10,000 to $50,000 and $100,000. There is not, as might be expected, any correlation between the amount of the limits carried and the size of the insuring hospital.

Half the hospitals in the group have specific insurance against the possibility of boiler explosion. Limits vary from $10,000 to $50,000 with $25,000 the average. In one case the policy is written specifically to cover loss due to sterilizer explosion as well as boiler explosion.

Several hospitals have blanket bonds of from $10,000 to $50,000 covering possible surety losses. The usual procedure, however, is for a small policy of $2000 to $5000 to be written bonding the one or two employes, such as the cashier, office manager or administrator, who may be handling hospital funds.

Not a single hospital in this survey carries group life insurance for hospital employes. Only two of the responding hospitals have an employes' retirement plan; in each of these hospitals, however, the hospital and not the employe pays the premium cost of the retirement program. Seven hospitals in the group report that employes are enrolled in the local Blue Cross plan. One of these hospitals pays Blue Cross membership fees for employes. Two hospitals report that employes are enrolled in a hospitalization plan other than Blue Cross.

INSURANCE COVERAGE IN SMALL HOSPITALS

REGION	BEDS	POPULATION OF CITY	FIRE INS. COVERAGE	OTHER PROPERTY INSURANCE	PCT. INCR. IN COVERAGE IN LAST 5 YEARS	HOSPITAL LIABILITY & MALPRACTICE	BOILER EXPLOSION INSURANCE	SURETY BONDS	EMPLOYES' GROUP LIFE	EMPLOYES' RETIREMENT	GROUP HOSPITALIZATION
East	86	8,000	$288,000		32	$10-$20,000	$10,000	$10,000	No	No	No
East	35	20,000	63,300	Sprinkler	None	10-30,000		50,000	No	No	No
East	98	14,000	110,000		None	None		5,000	No	No	Blue Cross
East	50	28,000	68,000		None	10-20,000		5,000	No	No	Blue Cross
Midwest			814,000	Burglary	None	50-100,000		2,500	No	No	No
Midwest	50	5,000	50,000	Tornado	33	5-15,000†		2,000	No	No	Yes
Midwest	100	70,000	115,000	Burglary	20	15-30,000	25,000*	None	No	No	Blue Cross
Midwest	37	6,000	90,000			5-15,000		Blanket	No	No	No
West	42	5,000	100,000		100	5,000	25,000	5,000	No	No	Blue Cross
West	53	28,000	270,000	Burglary	200	50,000	50,000		No	Yes**	Blue Cross
West	100	25,000	951,000	Burglary	50	25-100,000	20,000		No	Yes**	Blue Cross**
West	30	6,500	30,000		100	45,000	30,000		No	No	No
South	100	7,500	289,000	Tornado	50			5,000	No	No	No
South	32	2,500	65,000		25	None			No	No	Yes
South	55	5,000	31,000		None	None		10,000	No	No	No
South	90	4,000	145,000	Tornado	None	15,000	30,000	10,000	No	No	Blue Cross

†Includes staff doctors as well as hospital employes.
*Includes sterilizer explosion.
**Hospital pays premiums.

INSURANCE GETS INTO THE HOSPITAL ACT

E. E. SALISBURY
Executive Director, Chicago Hospital Council

THROUGH the Chicago Hospital Council, hospitals in Chicago and neighboring communities have recently worked out a plan under which patients who have commercial hospitalization insurance are admitted without delay, and hospitals provide insurance carriers with needed information, even though a number of different companies, all having policies with varying benefits, are involved.

In the past, when the hospitals recognized only the Blue Cross plan, they were subject to considerable criticism by many large business concerns which had, for one reason or another, chosen commercial group hospitalization insurance for their employes. This criticism not only stemmed from the management but also came from individuals who thought they had provided against the contingency of sickness and hospitalization but found that their insurance was not acceptable to the hospitals.

The reason for the hospitals' position is obvious when one considers the number of companies now in this field, each of which has many different types of contract, providing a variety of benefits. Not only was it impossible for the hospitals to be informed of the amount of coverage any patient might have but they were also unable always to determine if the individual's insurance was actually in force. The situation was further complicated by the fact that each company had its own individual forms for the hospital reports and its own requirements with regard to the validity of any assignment which it would recognize. When we first met with representatives of the insurance underwriters association, it seemed that it would be impossible to develop any plan that would provide the necessary information and, at the same time, be workable from the standpoints of both the hospitals and the insurance companies.

The first step was to have the companies agree upon uniform assignment and hospital report forms. It was also necessary that they accept the hospital's report without requiring the signature of the attending physician. Since the information was taken from hospital records, it seemed unnecessary to require the hospital to obtain the doctor's signature on the report. The accompanying forms were agreed upon by all of the companies and accepted by the council's committee. They are brief and yet supply all of the information necessary in connection with group insurance. It should be noted that a consolidation of the hospital and assignment forms is now under study. No attempt was made to bring individual contracts into the program because of their "preexisting illness" clauses and other numerous exceptions. The plan was restricted entirely to the group insurance contracts.

The next problem was that of providing some means that would allow the hospital to verify the coverage and determine the amount of benefits. This was accomplished by providing all of the insurance companies with a supply of the group hospitalization and admission cards. One of these forms was completed for each business or group that was enrolled by the company. Some had as many as three and four hundred group contracts in force in Cook County.

The card is self-explanatory, and it was decided that the file would have to be arranged by groups rather than simply by insurance companies. Many people know that they have hospital insurance but may not know the name of the company with which the coverage is carried. Under this plan all that is needed is for the patient to say that he is employed by X company and then it is a simple matter for the admission clerk to run through the file, and the card for X company will indicate the name of the carrier.

The admission card forms were returned to the Chicago Hospital Council after they had been filled out by the insurance companies and the information was then transferred to regular card stock. It was surprising how complete the information regarding benefits and other allowances was, and little difficulty is anticipated in determining the actual amount that may be expected from the insurance.

The council has provided a steel filing cabinet complete with the admission cards to every hospital in Cook County, regardless of whether it holds a membership in the association. It was felt that if the program were to be successful all hospitals should have an opportunity to participate. In addition to the filing cabinet, the hospitals were supplied with 100 copies of the printed assignment and report forms. Additional forms are available at any time and it is anticipated that the

GROUP HOSPITALIZATION ADMISSION CARD

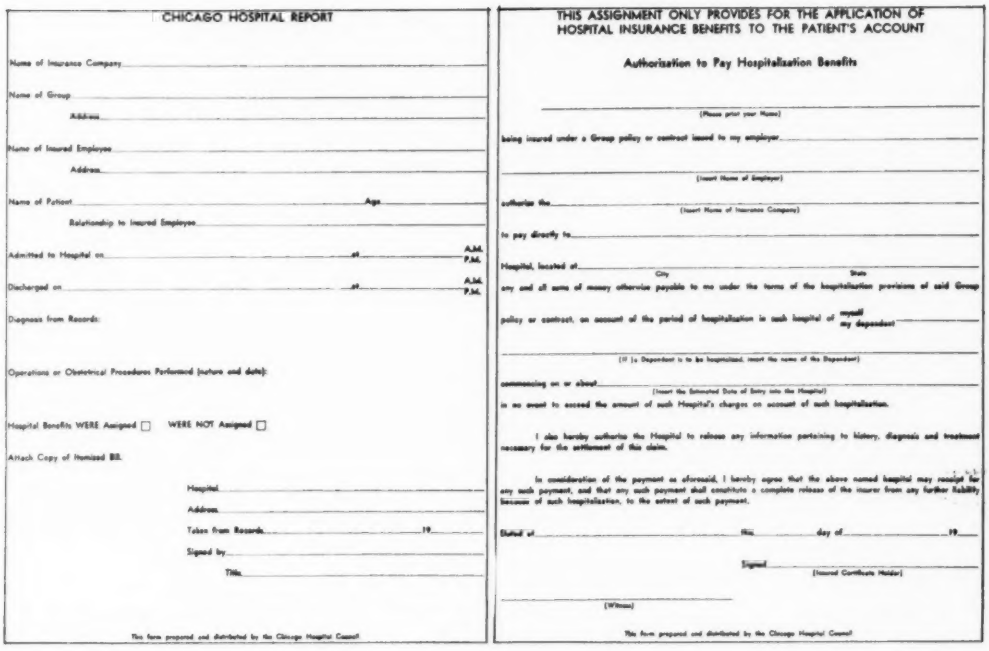
GROUP_____ CONTACT_____ for Hospital Insurance Information
ADDRESS_____ TELEPHONE NO._____
INSURANCE COMPANY_____
Mail Authorization to Pay blank to_____
Attention_____

IMPORTANT NOTE: In all cases of (1) Maternity, and (2) Confinement for less than 18 hours, inquire whether the individual is eligible for benefits.

Number of Days Covered: Employees			Dependents	
Class	Employees		Dependents	
	Daily Benefit	Misc. Expense Limit	Daily Benefit	Misc. Expense Limit
Maternity Benefits	Employees			
	Dependents			

Occupational Sickness and Accidents Are Not Covered

REMARKS



CHICAGO HOSPITAL REPORT

Name of Insurance Company

Name of Group

Address

Name of Insured Employee

Address

Name of Patient Age

Relationship to Insured Employee

Admitted to Hospital on at A.M. P.M.

Discharged on at A.M. P.M.

Diagnosis from Records:

Operations or Obstetrical Procedures Performed (nature and date):

Hospital Benefits WERE Assigned ☐ WERE NOT Assigned ☐

Attach Copy of Itemized Bill.

Hospital

Address

Taken from Records 19

Signed by

Title

This form prepared and distributed by the Chicago Hospital Council

THIS ASSIGNMENT ONLY PROVIDES FOR THE APPLICATION OF HOSPITAL INSURANCE BENEFITS TO THE PATIENT'S ACCOUNT

Authorization to Pay Hospitalization Benefits

(Please print your Name)

being insured under a Group policy or contract issued to my employer

(Insert Name of Employer)

authorize the

(Insert Name of Insurance Company)

to pay directly to

Hospital, located at City State

any and all sums of money otherwise payable to me under the terms of the hospitalization provisions of said Group policy or contract, on account of the period of hospitalization in such hospital of myself my dependent

(If a Dependent is to be hospitalized, insert the name of the Dependent)

commencing on or about

(Insert the Estimated Date of Entry into the Hospital)

in no event to exceed the amount of such Hospital's charges on account of such hospitalization.

I also hereby authorize the Hospital to release any information pertaining to history, diagnosis and treatment necessary for the settlement of this claim.

In consideration of the payment as aforesaid, I hereby agree that the above named hospital may receipt for any such payment, and that any such payment shall constitute a complete release of the insurer from any further liability because of such hospitalization, to the extent of such payment.

Dated at this day of 19

Signed

(Insured Certificate Holder)

(Witness)

This form prepared and distributed by the Chicago Hospital Council

council will continue to supply all of the hospitals' requirements.

A rubber stamp marked "Benefits Assigned" was included in each file, which is to be used on any hospital bill that may be given to the family if there has been an assignment of the insurance benefits. This was considered desirable to prevent possible isolated cases where the itemized bill might be given to the employer or insurance company in an attempt to obtain payment directly, even though an assignment had been executed.

Every insurance company authorized to write group insurance was invited to participate. It is believed that the initial plan has practically 100 per cent cooperation from those companies writing group contracts in the Chicago area. There are 44 companies represented in the program, with more than 2600 separate group contracts in force. This means that the file contains more than 2600 cards.

Because many of the existing contracts were written several years ago, the companies are now engaged in the process of increasing the benefits of their group contracts to meet increased hospital costs. Whenever the benefits are changed, or a new group is enrolled, the company forwards a new hospital admission card to the council. It is expected that, to keep the file current, it will be necessary to have new cards printed, to be forwarded to each hospital, about once every two months. A letter will be sent out in the interim, notifying the hospitals of any changes or new enrollments so that their files will always be up to date.

The expense of the program, which is expected to amount, roughly, to $4000, was divided among the 44 participating insurance companies on the basis of the number of groups which each one had. The initial printing, and cost of the forms and files, amounted to approximately $1.75 per card.

There can be no question of the public relations value in extending this consideration and cooperation to the business concerns, insurance companies, and thousands of individuals who have commercial group hospital insurance. It is difficult to explain to an individual who has had the foresight to provide for hospital insurance and who has been paying premiums for such protection that he cannot apply the benefits on his hospital bill. It is estimated that somewhere between three and five million dollars a year is paid out in benefits by the commercial insurance companies in the Chicago metropolitan area.

Although, under our present economic conditions, hospitals have not encountered any unusual difficulty in their collections, it is not inconceivable that the time may come when the assignment of benefits will be most welcome. It is expected that the individual who has such insurance will be allowed to apply the benefits through an assignment, in lieu of the cash advance deposit or as an application on the total bill, at the time of discharge.

The question arises, naturally, as to how long hospitals will have to wait before receiving payment on the assignment. Any prolonged delay, in consideration of the constantly increasing percentage of patients who have such insurance, could constitute a financial problem. Experience, of course, will afford the only accurate answer; however, the companies have indicated that, in practically all instances, payment should be made within a period of from 15 to 20 days from date of the assignment. Many firms that have Chicago offices have assured that payment will be made within an even shorter period of time.

About People

Administrators



Dr. Roger W. DeBusk has been appointed director of the Lancaster General Hospital, Lancaster, Pa., a 250 bed institution with a 200 bed addition in the planning stage. Dr. DeBusk, who went to Lancaster June 1, has been engaged in hospital consultation in the East since his resignation as executive director of the Evanston Hospital, Evanston, Ill., last fall. While at Evanston, Dr. DeBusk served as president of the Chicago Hospital Council and section chairman of the Illinois Hospital Association.

Thomas T. Murray has resigned as administrator, Columbia Memorial Hospital, formerly Hudson City Hospital, Hudson, N.Y. Mr. Murray was at one time superintendent, Memorial Hospital, Albany, N.Y., and more recently held the same position at White Plains Hospital, White Plains, N.Y.

Dr. Alvin R. Sweeney has resigned as head of Gallinger Hospital, Washington, D.C. He has been succeeded by **Dr. P. A. E. Stebbing,** formerly assistant superintendent. At the same time it was announced that **Dr. Joseph F. Fazekas,** chief medical officer of Gallinger, will become chief of staff, replacing **Dr. P. S. Rossiter.**

Dr. Claude W. Munger has resigned as regent of the American College of Hospital Administrators. His position on the board of regents will be filled by **Dr. Fraser D. Mooney,** director of Buffalo General Hospital, Buffalo, N.Y.

Rudolf G. Hills, assistant administrator of Buffalo General Hospital, Buffalo, N.Y., has been appointed president of the board of trustees of De Graf Memorial Hospital, Tonawanda, N.Y. He will continue in his position at Buffalo General. Mr. Hills has served as president of the Western New York Hospital Council and is a member of the board of trustees of the New York State Hospital Association.

Philip Houtz of New York has been named executive director of the National Jewish Hospital at Denver and secretary of its board of trustees. He succeeds **Samuel Schaefer,** executive director for 25 years, who died of a heart attack on April 20. Mr. Houtz has been director of the hospital's office in New York City for 11 years.

Robert M. Gantt Jr. has been appointed administrator of Roanoke Chowan Hospital, Ahoskie, N.C., which was opened last September.



Vernon D. Seifert has been appointed director of the clinics at St. Luke's Hospital, Chicago. Mr. Seifert will be in charge of the outpatient department, which was moved into a new building last month and is expected to expand from the present volume totaling 40,000 visits annually. Mr. Seifert is a graduate of the Northwestern University program in hospital administration and was formerly an assistant administrator at the Evanston Hospital, Evanston, Ill.

Dr. Edwin P. Kolb has retired as superintendent of Suffolk Sanatorium, Holtsville, Long Island, N.Y., after 33 years of service. Under his administration the sanatorium has grown from a 44 bed institution to one of around 200 beds. He will be succeeded by **Dr. Cecil Schultz,** superintendent of Orange County Sanatorium, Newburgh, N.Y.

Eric B. Barton, assistant to the superintendent of Emory University Hospital since 1945, is now superintendent of the Strickland Memorial Hospital, Griffin, Ga. He will head the new hospital now under construction in Spalding County, Georgia.

Dr. Charles Buckman, since 1941 assistant director of Creedmoor State Hospital on Long Island, has been named to take over the directorship of Gowanda State Homeopathic Hospital, Helmuth, N.Y. Dr. Buckman has been a staff member at Creedmoor since 1934.

Alfrieda Z. Cockrell has been appointed administrator of the Northern Inyo County District Hospital, now under construction in California. Miss Cockrell received her master's degree in hospital administration from Northwestern University.

Kenneth L. Winters will leave the Malden Hospital, Malden, Mass., to take over his duties as administrator of the Olean General Hospital, Olean, N.Y., on July 1.

Leon A. Bondi, administrator of Galesburg Cottage Hospital, Galesburg, Ill., has been appointed administrator of St. Luke's Hospital, Inc., Davenport, Iowa, to succeed **J. Richard Johnson.**

James D. Stoudenmier Jr. has been appointed superintendent of the Nan Travis Memorial Hospital, Jacksonville, Tex., where he succeeds **Ethel Stinson.** Mr. Stoudenmier had been chief accountant and business office supervisor for the last two years at Southern Baptist Hospital, New Orleans.

Roy Stephenson has been appointed administrator, Idaho Falls Latter-Day-Saints Hospital, Idaho Falls, Idaho. Mr. Stephenson is a graduate of the Columbia University course in hospital administration and served his administrative residency at Harper Hospital, Detroit.



Otto Bodemer is leaving the Illinois Masonic Hospital, Chicago, to accept an administrative position on the staff of the Institute for Living, Hartford, Conn. Before going to Illinois Masonic, Mr. Bodemer was purchasing agent at Wesley Memorial Hospital, Chicago.

Polly Hunt has been appointed administrator of the Sceva Speare Memorial Hospital, Plymouth, N.H. A member of the class of 1942 in hospital administration at the University of Chicago, Miss Hunt will receive her master's degree this June. She served an administrative internship at St. Luke's Hospital, New York City, and from 1943 to 1946 was on active duty in the navy. For the last year she has been administrative assistant at the Franklin Hospital, Franklin, N.H.

(*Continued on Page* 168.)



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THE BIG ISSUES THAT FACE TRUSTEES

RAYMOND P. SLOAN

THE progressive development of our voluntary hospitals from their original concept of homes for the sick to modern community and rural health centers infers new thinking and planning on the part of trustees. There is an unmistakable future challenge as well in the trend toward nationalization of medical and hospital facilities as practiced by England and certain other countries.

The question presents itself whether our hospitals shall continue in the true American tradition. Also what are the trustees' responsibilities to help preserve that American tradition.

WE MUST FACE REALITY

Our forefathers who served on the boards of voluntary hospitals fought for the preservation of their individual institutions. We, too, have been fighting, many of us, for the preservation of our individual institutions. Those buildings with honored names have meant more to us perhaps than the over-all community health service. We have thought too much about erecting monuments of steel and stone for personal satisfaction and too little about developing a comprehensive voluntary hospital and health plan. The time has come when we must face reality. The issue before us is voluntary *versus* government sponsorship.

Every hospital trustee has need to weigh the situation carefully. He has need, first, to look farther than his own horizon, to familiarize himself with the broader functions of hospitals operating under voluntary auspices as centers for curative, as well as preventive, medicine. Second, he has need to assume leadership in going to the public with the true facts. For at this point the public does not know. It has no definite information on which to estimate the extent to which government should assume responsibility for its medical care or to judge what its effects might be.

Too frequently the hospital trustee has been chosen for his ability to render some specific service—to supply legal counsel, to give financial advice, to assist in maintenance problems, to provide the answer to engineering difficulties. He has been encouraged to become involved in administrative details, when instead he should have been studying the over-all picture, analyzing trends in hospital and medical care, participating in legislative issues, delving into regional and state planning, all the while interpreting his findings to the public and developing a vast army of supporters of free enterprise in hospital and medical affairs.

Some extenuation for the trustees' intervention in administrative details in the past may be attributed to lack of competent management. Formerly no one estimated the requirements of hospital administration. There were no standards by which to judge. Sensing insecurity on the part of his administrative officer, the trustee took over in varying degrees.

Today that need no longer exists. Through the activities of the American College of Hospital Administrators, the American College of Surgeons, and the American Hospital Association, we are assured competent operation. Hospital administration is now recognized as a profession.

Let the trustee then fulfill his primary function of providing a proper administrator for his institution and, having done so, permit that individual to run it. Significant is it to note in certain instances the replacement of the appellation "superintendent" by the prefix "executive vice president," denoting true executive power. Yet, it was not too far back that the administrator was not permitted to attend board meetings.

AUTHORITY IS DIVIDED

It has been said, and truthfully, that our hospitals are loosely run, with authority divided in many instances among trustees, administrators and medical staff. If hospitals represent the big business we like to talk about, let's have trustees who act like big businessmen, not petty officers. Let them exercise their talents on the big issues and not concern themselves with electric bulb snatching. Let them truly lead and not block, interfere or harass. Should the trustee become suspicious that all is not well within the areas of administrative practice, let him obtain professional counsel and not toy with the delusion that he knows the answers.

Suppose we look farther into the so-called "big issues" in which the trustee should engage. What are they?

Maximum service to the public under voluntary auspices implies greater attention by the trustee to medical affairs. Too often his attitude has been one of "hands off." It is only within the past few years that the importance of closer accord between trustees and medical staff members has been recognized. Fortunately, we now

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find more frequent gatherings of trustees and doctors, also greater activity among coordinating or joint medical conference groups. All of this augurs well for the future—full recognition on the part of trustee and physician of their individual and collective problems.

Is the trustee who accepts without reservation the word of others on staff appointments fulfilling his complete obligations? Should he not be sufficiently interested to do some checking on his own? After all, it is he who is responsible for the quality of medical care rendered by the institution.

It is not unreasonable to expect that the trustee should investigate the status of medical staff audits in his institution, that he should insist upon some measure of professional results as he would gauge his own end-product or service.

He should be weighing the possibilities of group practice both within the hospital and in connection with groups of physicians outside. And what about the relationship between the hospital and private practitioners, particularly general practitioners?

POSSIBILITIES OF HOME CARE

The trustee should be evaluating the possibilities of home care programs for long-term and convalescent patients, thus taking the hospital to the people and saving beds for the critically ill. Such a plan of extended medical service with the hospital as its base might well reduce the number of required beds and assure equally effective service at reduced cost.

The trustee should be giving thought to what the voluntary hospital can and should accomplish in preventive clinical medicine, in the rehabilitation of the physically handicapped, in cancer detection work, in the practice of psychosomatic medicine.

There is need to exercise greater regional control over hospital expansion. Economic pressure demands the critical appraisal of every proposed building or development plan. The survival of the individual institution will be determined by its part in the over-all health program. Certainly these are matters to engage the attention of the hospital trustee.

What is the just responsibility of governments, private charity, voluntary insurance plans, and the individual in financing the voluntary hospital of the future? High standards of medical and hospital care in this country are attributable to the ability and the determination of the American people to underwrite voluntarily the cost of medical progress. Again, is the trustee going to "sell out," or is he going to fight to continue in the American tradition?



These typify just some of the big issues with which the trustee has need to be engaging himself at this time, leaving to others better qualified and trained those duties that may fairly be classified as administrative. With the picture clearly before him of accomplishments past and present of voluntary hospital service, as well as its potentialities, he is ready to embark on his next proper function, which is that of public interpretation.

Again, let it be said that the public by and large does not know. It has little, if any, concept of what free enterprise has contributed to hospital service and medical research in this country. Without the facts before it, how can it hope to form intelligent opinions as to the extent to which government should go in altering a health pattern that in the main has proved successful?

The trustee has, or should have, these facts, and it is his responsibility to see that they are presented fairly and accurately to the public. Interpretation of voluntary hospital service should stem from the board, as the policy maker, out into the community. It should constitute a well conceived plan for telling the complete story of voluntary effort and accomplishment.

Therefore, let's see that we have men and women on our hospital boards who are qualified to speak for these voluntary institutions. Let such individuals serve as interpreters to associations of incorporators, hospital societies, and similar bodies forming the ancillary groups.

While at it, why not extend the membership of such organizations? Why place any limit on their enrollment? We need as many friends for our hospitals as possible. So let's make every man, woman and child in the community feel that he or she has a share in it. Let's go to them with our story. Let's bring them to the hospital in groups, so that they may see and learn for themselves. A tour service for various civic bodies—Rotary, Lions, Kiwanis and women's clubs—should prove educational.

Every trustee should survey the potentialities of women's auxiliaries as a means of public interpretation. Hospital auxiliaries, as we know, are in process of organization on a state and on a national basis. This vast army of half a million women is rapidly expanding. More power to them! They will wield that power, have no fear of it, once they get started.

PUBLIC RELATIONS MEDIUM

As valuable as is the service rendered by women in raising sums for equipment and special projects, of even greater importance is their public relations value, their voices raised in defense of voluntary endeavor. But before they can hope to interpret intelligently, they themselves must be taught and trained. This gives the trustee something to think about and to work for —vast armies of women who can tell the hospital story. What better medium can there be for getting the hospital message into the American home?

Let the trustee not forget the young people. The school children of today should be the hospital supporters of tomorrow. He must help them grow up in the American tradition of free enterprise.

On one occasion recently, a trustee admitted discouragement over what were presented to him as his responsibilities. There is no need for discouragement unless we continue with eyes closed to what goes on in England and certain other countries. This is no time for discouragement. This unquestionably is the time for action, intelligent action.

So, let the trustees get going, not tomorrow or the next day, but today! Let them get out beyond the hospital's four walls and take places up front on the firing line where they are needed . . . where they belong. Let them acquire the facts and the training with which to go to the public with the story. Then with those facts the public can decide whether we shall embark upon a new socialized health program or continue in the spirit of free citizenship which has been the substance of the American way of life.

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LOOK WHO'S PRACTICING MEDICINE NOW

LUCIUS W. JOHNSON, M.D.
San Diego, Calif.

FOR nearly a year Keene Steele* had been administrator of Ace-High Hospital. He had skated successfully on the thin ice of staff reorganization and had kept his head above water in the whirlpool of union negotiations. Looking back on this period he felt that he had shown the qualities suggested by his name, a certain acuteness of perception together with durability under stress. In short, he was pretty well pleased with himself, though intelligent enough to realize the danger of that state of mind.

His complacence ended abruptly as he looked up to see the pathologist and the radiologist entering his office. Each one of them wore an expression of fierce determination and carried in his hand a copy of the annual report that Keene had prepared for the meeting of the governing board. These two were brilliant men of high professional qualifications. Though of opposite personalities they often teamed together as if they felt the need for common defense against the rest of the staff and the administration.

TALKED TO CONCEAL THOUGHTS

"Keene, my boy," was the opening remark by Dr. Hall, the pathologist, "we think you're a pretty smart fellow in some ways, and there are even some things about you that we like, but you're so terribly wrong in other ways." Dr. Hall was an easy talker who used language principally to conceal his real thoughts. Conversationally, he never went where he was looking, and this devious attribute had earned him the nickname of "Front" Hall.

"What have I done now to merit your distinguished attention?" asked Keene.

"Without having a license, you have been practicing medicine, using the hospital as a device to conceal the fact," gritted Dr. Stone, the radiologist. A dour man, of few words and most of them bitter, his associates spoke of him behind his back as "Brim" Stone. "Here you are, condemned by your own report. It shows that the hospital took in more money for work done in each of our departments than the services cost, and that this money was diverted to the support of other departments. That is a most shameful form of institutional fee-splitting. It also lays the hospital open to the charge of practicing medicine, which corporations are forbidden to do."

ONLY THE PATIENT PROFITS

"You certainly make it sound serious," said Keene slowly, while he mustered ideas for his defense. "But I was taught that the objectionable thing about fee-splitting was the undermining of somebody's professional integrity for a cash profit to the individual. Since this is a nonprofit hospital, the patient is the sole person who profits by our flexible fiscal arrangements."

"You're a smooth article, Keene, always bringing in the welfare of the patient as a screen to hide behind while you put over those slick devices to take away our just earnings." This remark of Dr. Hall's, Keene felt, was a greasing of the ways for him to slide down, so he decided not to venture any farther for the moment. "The American Medical Association's Code of Ethics says, 'It is unprofessional for a physician to dispose of his professional attainments or services to any lay body . . . under terms or conditions which permit a direct profit from the fees . . . to accrue to the lay body employing him.' So you see, Keene, we've got to have a new deal."

"It seems to me," replied Keene, "that the whole moral issue depends on the use which is made of the so-called profits. In this case nobody puts them in his pocket. The hospital has, for many years, depended on earnings from your two departments to help us break even. That may not be a perfectly equitable arrangement, but it can't be changed over night. You make it appear that what has long been accepted as prudent management has suddenly become a crime."

SPECIALTY A PRIVATE BUSINESS

"Well, Keene, you have plenty of time to think it over," said Dr. Hall. "Our contracts have another month to run. Here are statements from our specialist societies, showing the types of contracts that will be acceptable. We both prefer the one in which the hospital rents us the space and we conduct our specialties as private businesses."

"This requires a lot of thought," replied Keene. "I must work out a plan and submit it to the trustees. I guess we'd better have the executive committee of the staff in on it, too."

"No!" roared Dr. Stone. "Our financial arrangements are confidential. The rest of the staff must not know how much we get."

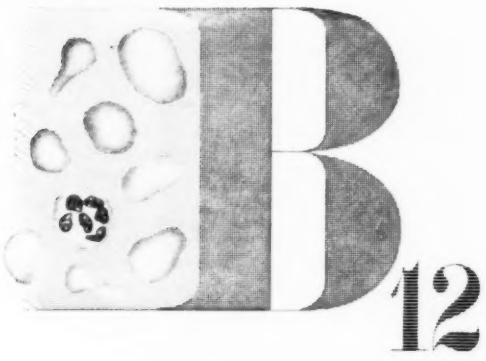
"But, Gentlemen, so radical a step as this, with such a vital change of relations within the hospital, should be based on the advice of the executive committee and not on the demands of only two members. Don't you agree?"

"Not at all. Our financial relations are not to be discussed with other staff members. I forbid you to mention this matter to any of them," Dr. Stone pounded his fist on the desk as

*Johnson, Lucius W.: Shall I Take That Job? Mod. Hosp. 70:43 (January) 1948.

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he spoke. Keene choked back the things he wanted to say and waited before replying.

"You must understand," he spoke slowly, "our relations are not quite like that. I am not your subordinate. I represent the trustees. I am their executive, who carries out the policies they determine, and most of those policies are decided with the advice of the executive committee of the staff."

"Oh! What fools we have been," groaned "Brim" Stone. "Why did we physicians ever let control of our hospitals slip out of our hands? Laymen and Sisters now presume to tell us what we must do and what we may not do in our own hospitals."

"I have a book I would like to lend you," Keene replied. "It is about the history of hospitals. It tells how they were started, not by physicians for their own profit and convenience, but by charitable and religious organizations for the benefit of the sick."

"It seems to me," Dr. Hall intervened hastily, "that we are getting pretty far away from the point. Let's stick to our knitting. All we require is that our new contracts provide for rental to us of the spaces and the equipment that we use in the hospital."

ENDANGER TAX-EXEMPT STATUS

"That would endanger our tax-exempt status," said Keene. "If we rent space to any person who uses it for his own profit, then we are in the real estate business, competing with banks and realtors, and are no longer a nonprofit institution. Having to pay taxes would close the hospital in a hurry."

"There is an alternative," Dr. Hall reminded him. "We will send out our own bills to private patients and will ask the hospital to collect for us from part-pay and Blue Cross patients. We will employ our own technicians and work out an agreement for prorating the cost of supplies. That would put us on the same footing as other physicians practicing in the hospital."

"They would think that it put you far ahead of them," Keene pointed out. "You must remember that you enjoy important advantages. You have no competition, while other practitioners have to give time, money and effort to impress the public with their competence. You get all the business from all the patients that the rest of the staff brings into the hospital. You keep regular office hours and are almost immune from night calls. Each of you enjoys a contract which assures you an income much higher than that of the average staff member."

"In other words," smiled Dr. Hall, "you are saying that we have been smart in choosing our specialties, and this we gracefully admit. Your remark about freedom from competition recalls the case of the man who peddled hot dogs in front of a bank. One day a friend asked him for a loan. The hot-dog man whispered in his ear, 'Don't tell anyone, but I have a secret agreement with the bank. They do not sell any hot dogs and I make no loans.'"

"To get back to the matter of the hospital practicing medicine," said Dr. Stone, "the attorney general of California has ruled that a hospital cannot pay a physician a fixed salary and then bill the patients for his services at rates unrelated to his salary. That would constitute practice of medicine by a corporation, and that is just what this hospital is doing. Also, the Code of Ethics of the College of American Pathologists states, 'It is unethical for a pathologist to accept a fixed stipend in a hospital . . . where other practitioners of medicine . . . receive compensation on a fee-for-service basis.'"

"Yes, I know about that, and it has thrown many first-class hospitals into a tail spin," answered Keene. "Several suits have already been started to determine the scope and application of that decision. A number of hospitals have found a solution of the problem by having the x-ray films taken by a technician and then sending them out to a competent radiologist who charges a flat rate for interpreting them. This amount is then included in the patient's bill. Tissues are sent out for diagnosis in a similar manner. Registered technicians, of course, are competent to handle urine and blood tests, except a few special ones. Perhaps that would be the best arrangement for this hospital."

"It certainly would not!" roared Dr. Stone. "The patients would never be satisfied with such inferior service. You must consider the welfare of the patients."

"Look who's using the patient as a screen to hide behind now," jeered Keene. "The members of the staff are the only ones able to judge the quality of the specialty service, and I feel strongly that any change in your status needs first to be approved by them. As far as the patients are concerned, both of you have so far lost touch with their point of view that you don't hear their daily demands that payment for service in the hospital be simplified and put in a single package. If, besides the hospital's charge, they get separate bills from the pathologist, the radiologist, the anesthesiologist, and perhaps the specialist in physical medicine, that will have a most damaging effect on our public relations."

"I guess Dr. Frank Lahey was right," commented Dr. Hall. "He warned us that unless physicians pay more attention to management of hospitals they will find themselves managed by hospitals, and that physicians must keep themselves in the driver's seat, to control the policies of the hospitals."

WELCOME GREATER INTEREST

"The trustees and I would welcome greater interest of the staff members in the details of management of the hospital," replied Keene. "If you had a better understanding of the complicated financial problems of the institution you would not demand sudden and radical changes which affect the relative status of all the workers. If you will follow through with Dr. Lahey's idea, I suggest that every staff member attend a half-hour daily session in which I will analyze this annual report, point by point, with questions by the audience. Then we can devote a session to each department of the hospital, with a study of its problems and its relation to the whole institution. How about it?"

"There you go again, Keene, with your slick arguments," said Dr. Hall. "Which one of the staff has half an hour to waste on that sort of thing?"

"That, Gentlemen, is exactly why hospital administration has reached the dignity of a profession, devoted just as yours is to the welfare of the patient. If we all keep this one object in view and exercise a little patience and tolerance, we can work out a solution of this problem that will be acceptable to all parties."

"You're right, Keene, my boy," said Dr. Hall as the two specialists rose to leave. "We mustn't whipsaw that fellow who is caught between us. We'll keep turning this over and discussing it until we work out something that is fair to the patient and to all of us."

"That goes for me, too," growled "Brim" Stone.

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ESTROGENS

THE large number of estrogenic preparations now available and the concurrent and often conflicting claims of benefits for each may engulf the physician and pharmacist in a morass of confusion and misinformation. The purpose of this brief survey, therefore, is to separate the various preparations into readily recognizable groups and, if possible, describe the characteristics of each group. This survey is confined to substances having follicular or estrogenic activity.

ASSAY

Biological assay played an important rôle in the early development of estrogen therapy. The rat unit (R.U.), as a measure of estrogenic activity, was established by Allen and Doisy. All estrogenic preparations may be assayed by this method, but since the method uses a fixed time-response effect, the results of such assays are obviously misleading when applied to long-acting estrogenic esters. The preparation of pure crystalline estrogens helped to define and establish units of assay. For example, 1 mg. of estrone is defined as 10,000 International Units (I.U.). Note, however, that this unit, I.U., is applicable only to preparations of *estrone*. Other units had to be established for such preparations as estradiol benzoate.

The following approximate equivalents may be of interest:

1 mg. estrone—
1000 R.U. (10,000 I.U.)
1 mg. alpha-estradiol benzoate—
6000 R.U.
1 mg. alpha-estradiol—
12,000 R.U.

This table based on biological assay, as indicated, fails to show the true effectiveness of alpha-estradiol benzoate since this compound has a longer action than alpha-estradiol. This difference in duration of activity is not reflected by the biological assay.

The uncertainty inherent in all biological assays and the failure of this method to indicate the duration of activity make it desirable to prescribe estrogens by weight. This problem is not confined to estrogens. It is generally true that when we know little of the chemistry and pharmacology of a drug, we use units of activity which are often derived from biological assay. When our knowledge has increased and pure substances and derivatives are available, we discard the biological unit and prescribe the pure drugs by weight.

NATURAL ESTROGENS

Estriol is a crystalline estrogenic steroid derived from pregnancy urine. It is about one-sixth as active as estrone when given parenterally. It is usually prescribed in doses of 0.06 to 0.12 mg. by mouth.

Estrone is one of the more important estrogenic substances found in pregnancy urine. It is probably the first degradation product of alpha-estradiol and is less active than alpha-estradiol. Estrone is usually administered parenterally, although with greater dosage the obstacle of gastrointestinal inactivation may be overcome. Estrone is usually prescribed by weight, but I.U. may be used since it is the international standard.

Estrogenic Substances. These are water insoluble preparations and, in addition to a variety of trade names, are sometimes described as "solution estrogenic hormones" or simply "solution estrogens." They are highly concentrated oil solutions of noncrystalline mixed estrogens. Their activity is attributable to the estrone content although they do possess varying amounts of other estrogenic phenolic ketones extracted from pregnancy urine. These preparations are prescribed by I.U. which is logical in view of their estrone content; however, this may not give adequate consideration to their content of other estrogenic substances. As with estrone, these preparations may be given parenterally or orally.

Estrogenic Substances, Water Soluble. These preparations are also obtained from pregnancy urine. The chief active ingredient is said to be sodium estrone sulfate, which is water soluble. These preparations also contain varying amounts of other estrogens. The dosage, as might be expected, is similar to that of estrone and estrogenic substances.

SYNTHETIC ESTROGENS

Alpha-Estradiol is probably the most potent naturally occurring estrogen and is considered to be the true follicular hormone. It is about 12 times as active as estrone (based on R.U.). It is described here as a synthetic because it is commercially more practical to synthesize alpha-estradiol from estrone than it is to isolate it as such from natural sources. It is active orally and is usually prescribed by weight.

Alpha-Estradiol Benzoate. The therapeutic effects of estradiol are prolonged by esterification with benzoic acid. This compound is one of the most desirable of the parenteral estrogens because it is hydrolyzed in the body to release estradiol, the most potent natural estrogen; its long action lengthens the intervals between injections; it is relatively inexpensive and free from undesirable side reactions. The dipropionic acid ester, alpha-estradiol-dipropionate, can be employed for longer duration of action. Alpha-estradiol benzoate is available under the trade names: Dimenformon Benzoate, Progynon B and Ovocylin Benzoate.

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Dihydroxystilbene derivatives. These compounds differ from all those previously described because they do not possess a cyclopentenophenanthrene nucleus. They contain two hydroxyphenyl rings (or their direct derivatives) joined together by three, or usually two, carbon atoms. These carbon atoms carry additional aliphatic groups and in many cases are linked by unsaturated bonds. Examples are: Benzestrol, Dienestrol, Diethylstilbestrol, Hexestrol and Mestilbol. They are generally effective by mouth and are prescribed by weight.

Unfortunately, compounds of this group may cause side reactions, such as nausea and emesis. There is consequently some tendency to employ these preparations only when exceedingly high estrogenic activity is required, for example, in the treatment of prostatic carcinoma. Ethinyl estradiol may be employed to good advantage in the treatment of prostatic carcinoma.

Vitamin E. The need of vitamin E for the maintenance of pregnancy in rats has been known since the original observations of Evans and Bishop in 1922. However, after more than a quarter of a century of research the mechanism of its action and the rôle of vitamin E in *human* nutrition and therapy remain poorly understood. Unfortunately, there has recently been considerable publicity in the lay press regarding certain experimental uses of vitamin E. Such premature publicity is deplorable, not only because it may raise false hopes in the mind of the layman, but also because it is doubtful if news editors will devote as much space and publicity in the future to carefully controlled studies which may fail to confirm the original reports.

There now appears to be good evidence obtained by R. S. Finkler and several other authors confirming the report of Christy and indicating the efficacy of vitamin E in treatment of menopausal symptoms. The average dose used by Finkler was 30 mg. alpha tocopherol acetate per day in divided doses which gave varying degrees of benefit to 71 per cent of 66 menopausal women. Placebo medication was without beneficial effect. It should be noted that Finkler used alpha tocopherol acetate. Alpha tocopherol is the most active of the tocopherols and the acetate ester gives it stability. The material is effective by mouth and in terms of biological activity is probably more economical than mixtures of tocopherols. Alpha tocopherol acetate may therefore be used as a substitute for estrogens in those menopausal patients who have a familial or personal history of malignancy and for whom estrogen therapy is contraindicated.

THERAPY

The multiplicity of estrogenic preparations is matched only by the claims for indications for their use. As a general rule, it is well to remember that estrogen therapy replaces or substitutes for ovarian function and does not stimulate such activity. It is thus logical to use estrogens in the treatment of certain types of hypo-ovarian function, such as the menopause (natural or surgical) and selected cases of hypogenitalism. The treatment of the



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Patients should be closely observed until optimal dosage is established, for possible paradoxical effects or orthostatic hypotension.

1. Grimson, Marzoni, Reardon and Hendrix: Ann. of Surg., 127: 5, May, 1948.
2. Reich, N. E.: Med. Times, Jan., 1949.

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menopause should, however, consist of a gradual withdrawal of estrogen substitution and not the indefinite maintenance of the patient on estrogen replacement. As with all estrogen therapy, the patient as a whole must be considered. Proper examination should be made to rule out malignancies and adequate consideration should be given to other endocrine functions, the nutritional status, environmental and psychic factors, as well as any other conditions that may influence the physiological state of the patient.

The estrogens have been reported to be of value in the treatment of senile vaginitis, kraurosis vulvae and pruritus vulvae. Estrogens are useful in the relief of pain from engorgement of breasts postpartum, particularly when lactation is to be suppressed. To achieve this successfully, the treatment should be started shortly after delivery. Estrogens may be used for the interruption of prolonged menses particularly when the interval of cessation of bleeding is used to rule out pelvic lesions. Estrogens have been successfully combined with progesterone in the treatment of functional secondary amenorrhea of less than two years' duration. The use of estrogens in the treatment of gonorrheal vaginitis in children is now limited to those cases which fail to respond to therapy with antibiotics. Estrogens, together with progesterone, have been reported to be of value in the treatment of certain types of habitual abortion.

ESTROGENS AND CARCINOMA

A high proportion of animals who have a hereditary sensitivity will develop mammary carcinoma following the administration of estrogens. On the other hand, estrogens are being used for the treatment of mammary carcinoma in selected cases among very elderly women. This problem is being actively investigated at the present time and we may hope to have a clearer definition of this use of the estrogens in the future.

Estrogen therapy has been established as part of the management of prostatic carcinoma. Such therapy may or may not include orchiectomy. Side reactions in the male to estrogen therapy may include gastric disturbances, loss of libido and painful breasts. Such comparatively minor side effects must be weighed against the importance of adequately treating the prostatic carcinoma.

CONTRAINDICATIONS

The use of estrogens is generally contraindicated in the presence of a familial or personal history of carcinoma of the female genitalia or breasts. Estrogen therapy is contraindicated in the presence of fibroids which tend to bleed all too rapidly with the use of estrogens. If there is a history of endometriosis, estrogens tend to exaggerate or reactivate the condition if there has been destruction or removal of the ovaries. The wide availability of highly potent estrogenic materials and the large doses that are all too often given make it necessary to consider what toxic effects may occur. Estrogen in large doses may inhibit the anterior pituitary thus in turn suppressing other endocrine functions. High concentrations may inhibit the normal functioning of the testes and ovaries. Large doses will in some cases affect the calcium metabolism. The action of estrogens in stimulating uterine motility must be remembered when estrogen is suggested in the treatment of conditions such as dysmenorrhea and habitual abortion.—M. J. SCHIFFRIN, PH.D.



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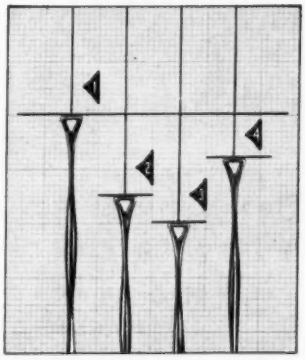
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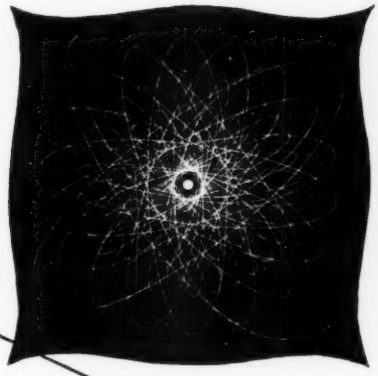
Group psychotherapy, first used in 1905 by Pratt in the care of tuberculous patients, achieved wide popularity only during World War II. Started as a matter of expediency in the armed forces because of the shortage of psychiatric personnel, group therapy is now used in military, veterans', state and private mental hospitals for its own sake. Terhune and Dickenson of the Silver Hill Foundation for the Treatment of the Psychoneuroses in New Canaan, Conn., have reviewed the progress of this method in an informative, well organized article in the *New England Journal of Medicine* of Dec. 2, 1948.

The authors distinguish between treatment by a psychiatrist of the individual who is a member of a group, and treatment "through the interaction of members of the group upon each other." The latter is true group psychotherapy; it is a distinctive method with intrinsic values of its own. Therapy may be of the Freudian analytic type, or based on inspiration and suggestion such as are employed by Alcoholics Anonymous. A third, eclectic, method tries to reeducate the patient to understand his problems and achieve reintegration of the personality.

The therapist represents the understanding parent who accepts the individual members as they are. He should not lecture, but be a permissive leader who soon gives way to the authority of the group itself. The group provides its members with the emotional satisfactions that were denied them in childhood; it "becomes a substitute for lack of gratification in early life." Emotional tensions are released, members find that they are not alone in their struggle with difficult problems, guilt and anxiety are diminished.

Group psychotherapy is useful in caring for psychoneurotics, much less so when applied to psychotics or psychopaths. Not only is the method practical, but results have been good. The authors suggest that it could well be used in treating the psychoneurotics among the patients in general hospitals and outpatient clinics, a suggestion that merits the attention of every progressive hospital administrator. — EDWIN L. DEMUTH.

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Conducted by Mary P. Huddleson

Tuberculosis Sanatorium Poses

SPECIAL PROBLEMS IN MENU PLANNING

JEAN BLACK
Chief Dietitian
Central Alberta Sanatorium
Calgary, Alta.

MENU planning in a tuberculosis sanatorium requires constant awareness of the following factors:

1. The dietitian is dealing with a patient whose nutritional needs are greater than those of a normal person.
2. She will be dealing with that patient for some time.
3. The food costs are met by a government subsidy, the amount of which is determined by the institution's estimates for the fiscal year ahead.

The recommended allowances for tuberculous patients follow closely Canada's Official Food Rules[1] (approved by the Canadian Council of Nutrition) but additional stress is placed on higher daily amounts of ascorbic acid, protein and caloric intake. The best guide to follow is that recommended by Dr. Kuphas, chief of the bureau of tuberculosis of the California State Department of Health. The guide was compiled after consultation with tuberculosis specialists at the medical school of Stanford University and the University of California.[2] It is as follows:

	Per Patient per Day
Calories	2500
Protein	85-125 grams
Calcium	0.8 gram
Iron	12.0 mg.
Vitamin A	5000 I.U.
Thiamin	1.5 mg.
Riboflavin	2.2 mg.
Niacin	15.0 mg.
Ascorbic acid	100-125 mg.

The standards set out in this guide are the first factors to be met in menu planning. To meet these the menu of each patient requires at least the following:

1. One quart of milk per day (including that used in cooking).
2. Five or six eggs per week.
3. Two servings of meat per day (or one serving of meat plus an adequate substitute).
4. One citrus fruit or serving of tomatoes plus one serving of other fruit, fresh, canned or dried, per day.
5. Two servings of vegetables—one of which is preferably raw—per day.
6. One serving of a whole grain cereal and five or six slices of Canada Approved bread per day.

As this sanatorium is located in the center of an agricultural district in the province of Alberta it is no great problem to include the proper amounts

[1] These rules are similar to the Recommended Daily Allowances for Specific Nutrients by the Committee on Food and Nutrition, National Research Council of the U.S.A.

[2] American Review of Tuberculosis—1946—Survey of Dietaries in Tuberculosis Sanatoria in 1943 and 1944 conducted by nutritionists of the California State Department of Health.

SUGGESTION LIST FOR SOUPS DETERMINED BY BASE USED

SOUPS BASE	BEEF STOCK	CHICKEN STOCK	HAM STOCK	VEGETABLE STOCK	LAMB STOCK	FISH STOCK
THICK		Mock Turtle Potage Mongol	Lentil Soup	Corn Chowder Potage Jackson Potage Malakoff Bean Soup		Oyster Bisque Lobster Bisque Sea Food Chowder
THIN	Beef Broth Beef Tea Oxtail French Onion Barley Broth Vegetable Soup	Chicken Broth Creole Tomato With Rice Tomato Bouillon	Potage Forestiere	Tomato Consommé	Scotch Broth Lamb Broth With Barley	Fish Broth Oyster Broth
CREAM		Cream of Chicken		Carrot Potato Corn Asparagus Pea Onion Squash Mushroom Celery Cauliflower		

MEAT SUGGESTION LIST—DINNER

BEEF	VEAL	PORK	HAM	CHICKEN	LAMB	MISCELLANEOUS
Roast Steaks Swiss Steak Farmers' Steak Hamburg Steak Corned Beef Minced Dutch Beef Stew	Roast Cutlets Chops Fricassee Veal Pot-pie	Roast Chops Tenderloin	Baked Steaks	Roast Fried Fricasseed Curried Creamed Pot-pie	Roast Chops Irish Stew	Baked Heart Tongue Sweet-breads Liver



Good Food for Pleased Guests

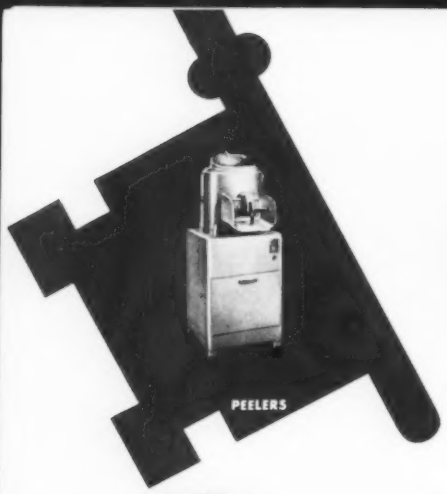
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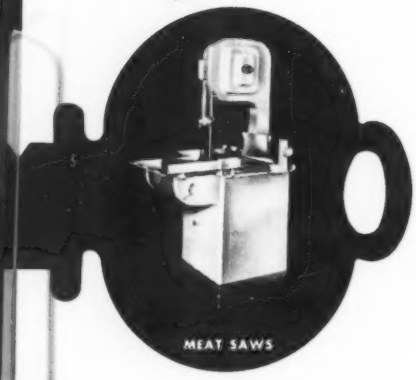


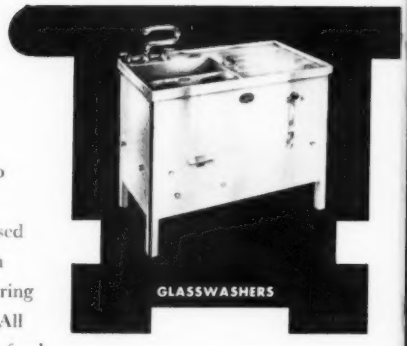


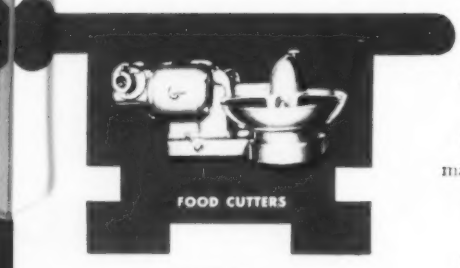


Pass-keys to Performance

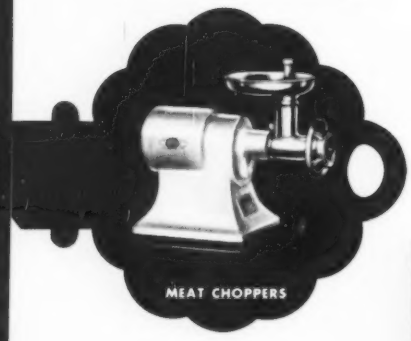
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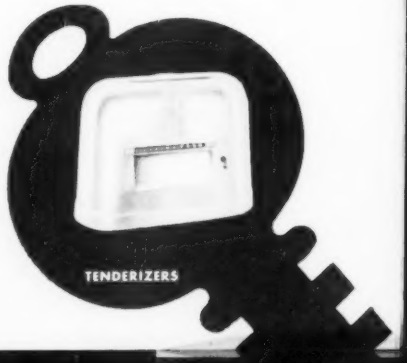
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of milk, eggs, meat, dairy butter and cereals in the menu.

In spite of a shorter growing season than most areas in the United States have, we can count on a reasonable supply of fresh fruits and vegetables from Alberta's neighboring province of British Columbia. Unfortunately, this supply of fresh fruits and vegetables from British Columbia is available only for six months of the year and the demand on Alberta, British Columbia and Saskatchewan markets is now greater than the supply. Until December 1947, these supplies from British Columbia were augmented by imports from the states of Washington and California. Since then a ban has been in effect on the import of certain fruits and vegetables, and consequently it has become more difficult to meet those nutritional needs that are supplied by fresh fruits and vegetables.

Frozen fruits and vegetables are a great help in menu planning during the winter months. Locker space is readily available on the Prairie and if it is possible to prepare our own produce the cost is quite low. We use frozen fruits and vegetables at least once a week as a change from a fairly steady diet of canned vegetables and fruit and such root vegetables as can be stored. In the winter, citrus fruits, bananas, frozen fruits and vegetables, carrots and cabbage are supplemented by canned fruits and vegetables. At this sanatorium canned fruits and vegetables are purchased commercially with the exception of some fruits which are purchased at cost from the mental hospital at Ponoka, Alta. Tranquille Sanatorium in British Columbia has a large farm operated for the use of the sanatorium and the dietetic department there is in charge of a small canning unit which manages to preserve some of its own fruits and juices.

Meats, poultry, grains and eggs are in abundant supply in Alberta and consequently protein is readily obtained. The main problem in menu planning to meet the nutritional requirements of the tuberculous patients is to supply the necessary maximum amount of ascorbic acid. The problem is most difficult during the months of November to April. American citrus fruits and juices and our own frozen and canned fruits and vegetables are our salvation.

The length and nature of the cure in this chronic disease are primary factors which must be constantly considered in a tuberculosis sanatorium. First, when the patient arrives at the sanatorium he comes prepared for a long stay and the sanatorium becomes the patient's home for at least one year and in extreme cases up to eight years. Second, the most effective cure discovered to date for arresting the disease is long periods of rest. These two factors tend to produce an existence which may soon become dull and monotonous. Meals are looked to as a diversion from a quiet routine and therefore they must be attractive. The menu must have frequent variation or the patient may lose his appetite; a consequent loss of weight will follow which may cause the resistance to the spread of the tubercle bacillus to be weakened.

Food must be eaten to be effective. It must be attractive as well as meet the nutritional needs of the patient. The road to effective menus, that is, menus which will meet the requirements for good variety in flavor, texture, color and appearance, is in the use of suggestion lists, as follows:

1. A suggestion list for soup. This list is compiled according to the stock base used and whether it is a thick, thin or cream soup.

2. A list of meats. The meats are listed as to type of animal with the cuts and ways of serving shown below. We list the suitable dinner meats first and follow this with supper suggestions.

A similar list may be used for various fish and shell fish.

3. For vegetables we use a list similar in form to those displayed, that is, the kind of vegetable is listed at the top with the way of serving it shown in columnar form below. We find it convenient to list the vegetables across the page in order of color so that the green vegetables are grouped together, and so on.

When the vegetables are arranged in the same color groups it helps our color arrangements in menu planning.

VEGETABLE SUGGESTIONS

GREEN				ORANGE			
SPINACH	PEAS	ASPARAGUS	GREEN BEANS	CARROTS	PARSNIPS	TURNIPS	SQUASH
Buttered With Vinegar Creamed	Boiled Creamed With Carrots	Buttered Creamed Creamed With Cheese Hollandaise	Steamed Creamed	Diced Mashed Slivered With Onions Creamed Baked Glazed With Peas	Diced Mashed Creamed With Green Pepper	Diced Mashed Creamed	Baked Steamed
CABBAGE	BRUSSELS SPROUTS	BROCCOLI	LETTUCE	SWEET POTATO	PUMPKIN		
Boiled Steamed Creamed Coleslaw Salad	Steamed	Steamed		Baked Mashed Candied			

DESSERT LIST

CAKE	COOKIES	PIES	TARTS	HOT PUDDINGS	COLD DESSERTS	FRUITS
Sponge White Butter Chocolate Spice Marble Banana Orange Date Loaf Maple Walnut Cherry Pound Fruit Queen Cup Cake	Vanilla Maple Spice Coffee Brownies Oatmeal Date Peanut Chocolate Chip	Apple Blueberry Cherry Plum Raisin Flapper Boston Cream Coconut Banana Cream	Apple Raisin Butter Jam	Chocolate Lemon Date Steamed Plum Cobblers Crisps	Spanish Cream Blanc-mange Gelatins Bavarian Ice Cream	Bananas Apples (Refer back to Fruit List)

4. Suggestion list for fruits.
5. Salad suggestions.
6. Dessert suggestions.

We write these lists on small loose-leaf paper that can easily be clipped into and taken out of a holder which keeps them in compact, readable form. We add to these suggestion lists continually as we find new recipes and ideas.

Then when the actual menu planning begins these suggestion lists are arranged in front of the dietitian in the order in which she is planning the menu. The breakfast menus for the week are planned first; next, the meats for dinner and supper, followed by the soup list, accompanying vegetables and salads, and finally the desserts.

The final check on the menus is for adequate nutritional content. To make this we try to conduct frequent diet surveys based on an actual menu for a day, determining the amounts of food each patient receives and then calculating in terms of calories, protein, calcium, thiamin, riboflavin, ascorbic acid, niacin and iron the actual amounts of these nutrients received by the patients.

This chronic disease hospital is owned and operated by the Provincial Government of Alberta. Each year government funds, the amount of which is determined by the sanatorium's estimates of costs for the fiscal year ahead, are put aside to operate this institution. These estimated costs, of course, include an item headed "Kitchen and Dining Room" under which are the amounts required for staff salaries, food costs, and repairs and renewal of equipment. On the basis of this estimate the money is allotted to feed the patients and staff for the year ahead.

It is the duty of the dietitian to keep within the budget figures. To ensure that she does so, a cost spread sheet is prepared monthly and she also keeps an eye on the cost statements of the kitchen and dining room that are prepared monthly by the business office of the sanatorium.

All general groceries are procured by tender which is called for every three months. This tender is based on: (1) the dietitian's estimate of three months' requirements; (2) the business superintendent's quotations on prices and his choice of the various firms from which the groceries may be bought.

All the food purchased is of the highest grade and definite stipulations regarding grade are sent out with the orders to the firms. Therefore, if the orders are not supplied correctly the goods are returned. If the dietitian needs any other general groceries she can purchase no more than 10 dollars' worth at one time, unless a requisition is sent first to the department of health of the government of Alberta at Edmonton for approval by the department's purchasing agent. Fresh fruits and vegetables are purchased daily by the dietitian, while meat and butter are contracted for by the month; fish, by the three months, and tea and coffee by the year.

This system permits us to use a good variety and quality of foods in menu planning and still keeps our expenditures within the limit of the budget.

Under the system of three-month tenders it is necessary to keep a check on our general groceries, particularly the canned fruits and vegetables, so that we do not either run up a surplus stock or have a shortage of any particular item.

In our planning we must keep the food cost factor in mind and check the menus often for the average cost per person per meal. It should not go above the average cost for the same period of the previous year unless there is some unavoidable reason, such as a higher food price scale generally. It is also the duty of the dietitian to see that the food costs are as low as possible without the food's being of such a quality that it is not eaten and therefore does not meet the maximum requirements of the patient.

Menu planning in a chronic disease hospital such as a tuberculosis sanatorium means producing a menu that meets the nutritional needs of the patients; satisfies their need for variety in meals; provides meals which are attractive in color, flavor and texture; stays within the allotted budget, and continues to keep a level average cost per person per meal.

The dietitian's duty in a chronic disease hospital is to contribute materially to the patients' recovery; to show them the results of good food habits, and to make their long stay as happy as possible under the circumstances. These aims can be accomplished if the dietitian plans attractive and varied menus and constantly keeps her objectives in mind.

FOOD FOR THOUGHT

FOOD FOR FOUR INCOME LEVELS. *By Ruth Okey and Mary Gorringe Luck. Published by the Heller Committee for Research in Social Economics, University of California. Berkeley: The University of California Press, 1948. Price $1.*

Of interest to the dietitian and social service worker concerned with family budgets for food is this authoritative compilation. The four income levels include that of an Executive, a White Collar Worker, a Wage Earner (each with his respective wife, a boy aged 13 and girl aged 8), and Dependent Families of Children.

Comparisons are made with earlier years and changes in cost of food since 1939. For instance the White Collar Worker's family could eat at home for $10.87 per week in 1939; in 1948 he had to spend $24.64, or a 126.5 per cent increase. (These estimates do not include week-day lunches for the head of the family.) Comparative prices as well are given for individual items of food for the years 1939 and 1948 with the percentage increase in each instance. Those one-time nutritional bulwarks of the low-cost diet—spinach, dried red beans, hamburger and canned salmon—interestingly enough show the highest percentage increases, namely, 366.7, 276.6, 243.5 and 233.7 per cent.

Sample weekly food budgets and quantity allowances per individual per week, along with sample menus, possible substitutions (calcium, protein) or equivalents, complete this excellent work. The administrative dietitian, too, will find it an excellent reference in checking her dietary allowances.—MARY P. HUDDLESON.

How Much for Food?

What influence income, geography and varying food habits have on the food families buy and what they pay for it shows up in food consumption surveys made in Minneapolis-St. Paul and Birmingham last winter. Figures

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for these two cities are the first to be tallied in a series of food consumption surveys recently completed by the Bureau of Human Nutrition and Home Economics, U.S. Department of Agriculture. The work is being done under the Federal Research and Marketing Act.

In Minneapolis-St. Paul, families interviewed were spending an average $24.40 a week—or 30 per cent of their average income—for food last winter. These 253 families spent an average $6.89 per person for food, including all food eaten at home or away from home, but not including food canned from home gardens or received as wages or gifts.

The 30 per cent compares with 37 per cent of average income which Birmingham families spent per week for food last winter. Minneapolis-St. Paul families actually spent more money—$24.40 compared with $21.67 in Birmingham—but generally higher incomes in the northern city account for the smaller percentage spent for food. The Minneapolis-St. Paul families were also slightly larger than were Birmingham households studied by the surveyors.

These differences in income and family size, as well as food habits, were also reflected in the use of certain food groups in the two cities. Minneapolis-St. Paul families consumed a third more milk or its equivalent in cheese, ice cream and cream than did Birmingham families. They used nearly a third more citrus fruits and 50 per cent more canned fruits and vegetables.

On the other hand, consumption of meat, poultry and fish, as a group, and of eggs was about the same in the two cities. But Twin Cities families used slightly fewer fresh vegetables during the winter weeks studied, a third less flour, bread and other cereal foods, a little less sugar, and a fourth less fats. Breaking down the figures on fats shows that the Minneapolis-St. Paul households used almost four times as much butter, while they used only two-fifths as much margarine and a fourth as much lard.

Results of the surveys include many other findings, including information on 186 different food items families use. Furnishing valuable facts for nutritionists and welfare workers who are concerned about better diets for Americans, they will be used too by farmers, food processers and market men.

HOW TO CUT LABOR COSTS. New York: *New York State Restaurant Association, Inc.*, 1949. $2.

This 69 page booklet presents the views of three executives in the commercial restaurant field and those of Drs. Ruth Gilbert and Mary DeGarmo Bryan, personnel consultant, and chief of the Department of Institutional Management, Teachers College, respectively. The five subjects discussed are: "How to Select Better Restaurant Employes"; "Training and Supervision"; "Record Keeping"; "Better Menu Preparation and Food Purchasing," and "Layout and Equipment Affect Labor Cost." Charts, diagrams and forms supplement the discussions which are equally applicable to the hospital food service.

Under selection of the employe, it is said that it costs from $8 to $105 to put a new employe to work, depending on the initial cost of finding, interviewing and training. Hence, the need of competency in selecting the employe. The eight steps in acquiring the employe are outlined and illustrated with application form, simple mental tests, telephone check forms, selection or "patterned" interview, all of which are designed to reduce labor turnover and maintain a stable, productive and satisfied group of employes. Training of the employe can be broken down into three parts: attitude, deportment and technic. The need to simplify each job by breaking it down into separate motions is stressed. Under "supervision," a sample chart is displayed which informs the manager where each employe is stationed and on what job he is engaged throughout the day.

Records should present a true picture of actual practice from which the soundness of the operation can be determined. Methods are shown by which the labor cost percentage for any period —from a year to a meal—and for any department—from bakery to sandwich counter—can be readily ascertained. The section on menu preparation and purchasing continues to show how to cut labor costs through menu simplification and the use of frozen and dried foods.

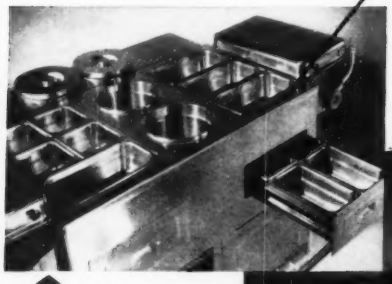
In the final section Dr. Bryan gives more than 50 practical suggestions for cutting labor costs by eliminating unnecessary walking and handling during preparation, service and cleaning. She analyzes the whole "flow process" for efficiency loss and gives specific recommendations for replacements and readjustments of existing layout and equipment.—MARY P. HUDDLESON.

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This new electrically-heated food conveyor is designed specifically for selective menus. It will contribute to successful diet-therapy in your hospital. Eighteen insets in various sizes can be placed in the wells in different combinations. These provide innumerable top deck arrangements to meet the requirements of any given meal. In addition to the two rectangular wells, there are two round wells for soup and broth and two heated drawers for special diets and rolls. The entire unit is made of heavy-gauge corrosion-resistant stainless steel. Top and body are of seamless, crevice-free construction, meeting the strictest hospital standards for sanitation and durability. If you're contemplating the "selective menu" idea, write for information about Model ALS-4922.



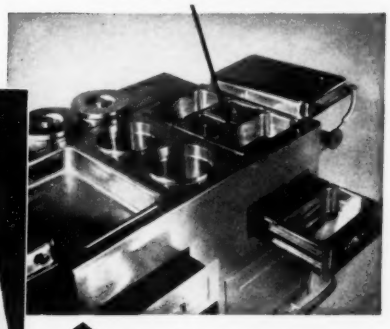
▲ EIGHTEEN square and rectangular stainless steel insets in various sizes can be arranged in many combinations.



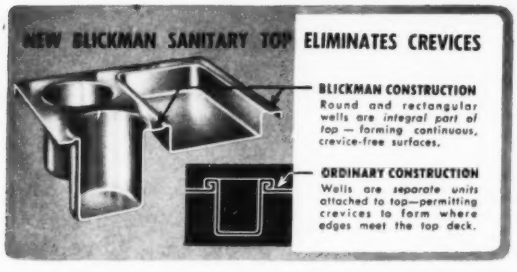
Above: Today's menu may call for four square and four rectangular insets as shown here.

Right: While tomorrow, square and rectangular insets may be arranged like this. ▶





Above: Still another arrangement is shown. Note the heated drawers and the convenient serving shelf.



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Menus for July 1949

Mrs. George H. Thompson
Memorial Hospital
Colorado Springs, Colo.

1
Fresh Applesauce
Poached Egg on Toast
•
Braised Sweetbreads
Buttered Beets
Pear and American Cheese Salad
Graham Cracker Roll
•
Halibut Bernaise
Twice Baked Potatoes
Fresh Broccoli
Fresh Royal Anne Cherries

2
Sliced Bananas
Link Sausages, Toast
•
Veal Fricassee With Rice
Marinated Green Bean Salad
Lemon Meringue Pie
•
Pot Roast of Beef
Oven Browned Potatoes
Macedoine of Vegetables
Ambrosia

3
Orange Juice
Omelet
•
Fried Chicken
Creamed New Potatoes
New Peas
Cantaloupe Balls With French Dressing
Strawberry Sundae
•
Grilled Cheese Sandwiches
Shoe String Potatoes
Relish Plate
Bartlett Pears

4
Grapefruit Sections
Soft Boiled Egg
•
Cold Roast Beef
Macaroni Salad
Lettuce With 1000 Island Dressing
White Cake
(Flag or firecracker motif inserted)
•
Baked Ham
Escalloped Potatoes
Grilled Tomato
Cherry Gelatin

5
Apricot Nectar
Biscuit Pinwheels
•
Eggs à la King on Toast
Hunter's Salad With Fresh Asparagus
Spiced Cup Cakes
•
Grilled Lamb Chops
Duchess Potatoes
Spinach Bechemel
Pineapple Tidbits

6
Sliced Orange
Scrambled Eggs
•
Cream of Mushroom Soup
Bacon and Tomato Sandwich
Waldorf Salad
Raspberry Shortcake
•
Veal Cutlet With Cream Gravy
Boiled Rice
Zucchini Squash
Caramel Custard

7
Stewed Prunes, Lemon
Poached Egg on Rusk
•
Cheese Soufflé
Fruit Salad
White Mountain Muffins
Chocolate Chip Ice Cream
•
Porcupine Meat Balls
Hashed Brown Potatoes
Cauliflower Duchess
Gingerbread With Banana Whipped Cream

8
Grapefruit Juice
Orange Muffins
•
Tuna Casserole With Peas
Coleslaw With Green Pepper
Chiffon Cake
•
Salmon Loaf With Hard-Boiled Egg Sauce
Baked Potatoes
Whole Kernel Corn
Fresh Fruit Cup

9
Tomato Juice
Coddled Egg, Toast
•
Spanish Omelet
Grapefruit and Celery Salad
Cherry Puffs
•
Chicken Fricassee With Noodles
Peas and Carrots
Seedless Grapes

10
Cantaloupe
Bacon, Cinnamon Rolls
•
Consommé
Small Steaks
French Fried Potatoes
Green Limas
Golden Glow Salad
Fruit Salad Ice Cream
•
Monte Carlo Sandwiches
Sliced Tomatoes
Fresh Peaches

11
Pineapple Juice
Scrambled Eggs
•
Ham Salad Sandwiches
Banana-Orange Salad
Chocolate Pudding With Marshmallow Sauce
•
Danish Pork Chops
Mashed Potatoes
Green Beans
Apricot Halves

12
Sliced Oranges
Link Sausages
•
Eggs Benedict
Lettuce With Avocado Dressing
Strawberry Icebox Cake
•
Roast Leg of Lamb
Parsley Buttered Potatoes
Minted Carrots
Celery Hearts
Peanut Butter Cookies

13
Kadota Figs
French Toast With Sirup
•
Escalloped Corn With Sausages
Tossed Green Salad
Dutch Apple Cake
•
Creamed Chicken on Hot Biscuits
Mashed Potatoes
Zucchini Squash
Fresh Raspberries

14
Half Grapefruit
Orange Bread
•
Home Style Vegetable Soup With Crackers
Sliced Cheese and Cold Meats
Apricot Salad
Coconut Cake
•
Roast Prime Ribs of Beef
Oven Browned Potatoes
Julienne Beets With Lemon
Fruit Gelatin With Whipped Cream

15
Fresh Applesauce
Canadian Bacon
•
Shrimp Salad
Potato Chips
Sliced Tomatoes
Olives
Hard Rolls
Cream Puffs With Chocolate Sauce
•
Breaded Scallops, Tartare Sauce
Creamed Potatoes
French-Cut Green Beans
Fresh Peaches

16
Tomato Juice
Poached Egg on Toast
•
Beef Pinwheels With Vegetable Sauce
Carrot and Raisin Salad
Custard Pie
•
Ham Loaf With Orange Sauce
Baked Sweet Potatoes
Fresh Broccoli
Fresh Bing Cherries

17
Pineapple Juice
Bacon Omelet
•
Lamb Chops With Mint Jelly
Parsley Buttered New Potatoes
New Peas
Jellied Cherry and Nut Salad
Lime Sherbet, Wafers
•
Cheese Rabbit on Toasted Bun
Baked Tomatoes
Cantaloupe

18
Grapefruit Sections
Bacon, Toast
•
Fresh Veal Tongue With Horseradish Sauce
Pineapple With Cream Cheese Balls
Fresh Peach Roll
•
New England Boiled Dinner
Raspberry Bavarian Cream

19
Orange Juice
Sausages, Muffins
•
Chicken Loaf With Parsley Sauce
Hearts of Artichoke Salad
Pineapple Upside-Down Cake
•
Braised Liver and Bacon
Baked Potatoes
Escalloped Corn With Green Pepper
Coffee Carnival

20
Cantaloupe
Soft-Boiled Egg
•
Vegetable Plate
Tomato Stuffed With Egg Salad
Tapioca Cream
•
Pot Roast of Beef With Dumplings
Mixed Vegetables
Meringue Pears

21
Grapefruit Juice
Banana Bread
•
Creamed Chipped Beef on Rusk
Avocado and Tomato Salad
Graham Cracker Roll
•
Chicken Fried Steaks
Mashed Potatoes
Fresh Wax Beans
Raisin-Rice Pudding

22
Sliced Oranges
Coddled Eggs, Toast
•
Crabmeat Cakes
Mashed Potatoes
Spiced Beet Salad
Devil's Food Cake
•
Fillet of Sole With Tartare Sauce
Au Gratin Potatoes
Stewed Tomatoes
Boysenberries

23
Apricot Nectar
Scrambled Eggs, Bacon
•
Hot Meat Loaf Sandwiches
Pear With Cream Cheese and Nut Salad
Grapenut Puff Pudding
•
Roast Veal With Dressing
Duchess Potatoes
Peas and Carrots
Peach Melba

24
Fresh Raspberries
Canadian Bacon, Rolls
•
Chicken Maryland
Mashed Potatoes
Asparagus Hollandaise
Mixed Fruit Salad
Peppermint Stick Ice Cream
•
Ribbon Sandwiches
Tomato Aspic
Apple Cobbler

25
Half Grapefruit
French Toast, Sirup
•
Macaroni and Cheese
Cabbage and Carrot Salad
Strawberry Pie
•
Ham Steaks
Oven-Browned Potatoes
Cauliflower au Gratin
Toll House Cookies
Fresh Fruit Cup

26
Tomato Juice
Baked Egg in Bacon Ring
•
Cold Smoked Tongue
Potato Salad
Relishes
Lemon Roll
•
Roast Prime Ribs of Beef
Mashed Potatoes
Fresh Spinach With Hard Boiled Egg
Chocolate Blancmange

27
Kadota Figs
Date Muffins
•
Lamb Stew With Vegetables
Cottage Cheese and Olives in Green Pepper Ring
White Cake With Orange Icing
•
Stewed Chicken and Noodles
Fresh Asparagus
Watermelon

28
Pineapple Juice
Country Sausages
•
Spanish Omelet
Tossed Green Salad
Blueberry Pie
•
Hamburger Steaks With Mushroom Sauce
Potatoes O'Brien
Harvard Beets
Green Gage Plums

29
Sliced Oranges
Poached Egg, Toast
•
Vegetable Casserole
Deviled Egg Salad
Banana Cake
•
Lobster à la Newburg
Baked Potatoes
Fresh Peas
Butterscotch Sundae

30
Fresh Applesauce
Raisin Bread
•
Chef's Salad With Ham and Chicken
Cheese Biscuits
Olives, Pickles and Celery
Boston Cream Pie
•
Meat Loaf With Brown Gravy
Escalloped Potatoes
Braised Carrots
Graham Cracker Pudding

31 Cantaloupe, Ham Omelet • Roast Prime Ribs of Beef au jus, Oven-Browned New Potatoes, Broccoli With Lemon Slice, Jellied Fresh Vegetable Salad, Ice Cream Roll • Chicken Salad, Latticed Potatoes, Sliced Tomatoes, Angel Food Cake

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Is the HEAT PUMP practical for institutional use?

J. DONALD KROEKER
Consulting Engineer
Portland, Ore.



THE development and application of the heat pump has caught the public fancy during the past few years as a mysterious device that obtains heat from "cold." As a result, applications have been made to many residential and commercial heating installations, ranging in size from equipment using 2 connected h.p. to as much as 550 h.p.

Probably because of the paradoxicality of obtaining heat from "cold," interest in the heat pump has far exceeded that reasonably warranted in view of the limitations attending its application.

The heat pump seems paradoxical only because of common misconceptions and loose usage of terms. Heat

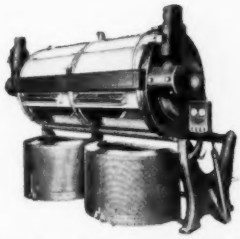


Four heat pumps, self-contained water chiller units, heat and cool the Equitable Building.



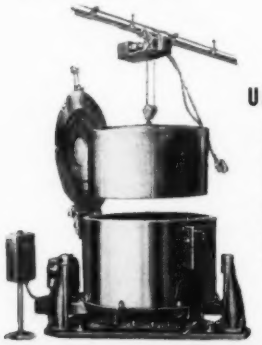
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INSTITUTIONAL LAUNDRY DIVISION • BRANCHES IN ALL PRINCIPAL CITIES

is a quantity as distinguished from temperature, which is a level or intensity. Like water, heat, though invisible, flows from objects of a higher level or temperature to objects of lower level or temperature.

We think of heat being present in objects warmer than room temperature, when actually there is heat in any object having a temperature greater than 459.8° below zero F. Heat will flow and is recoverable from substances having temperatures far below room temperatures.

The heat pump is merely a device that can extract heat from materials of relatively low temperatures and discharge this quantity of heat at a temperature sufficiently high to be useful in heating buildings. A refrigeration machine is one that does useful work in extracting heat.

The extracted heat is delivered to a material such as water or air, which is wasted. Conversely, the heat pump does useful work in supplying heat to a space after extracting it from a medium such as water or air, which is then wasted.

The equipment used in heating and refrigeration is virtually identical. A simple diagrammatic sketch of a typical refrigeration cycle used for heating is shown in figure 1. The compressor, condenser, receiver, expansion valve, and evaporator are inherent elements in any refrigeration cycle.

In the illustration, well water supplied at 56° and cooled to 48° is shown as supplying 30 Mbh. (1000 Btu. per hour) shown graphically in value by the cross hatched area. The heat of compression in the compressor, equivalent roughly to the heat equivalent of the power used to drive the compressor, increases this value to 40 Mbh. The temperature is increased in the compression cycle from 40° to 115°. The condenser through which the refrigerant then passes is a heat transfer unit, such as a coil, over which air is blown. Air entering the coil at 65° is delivered to the room at 95° in this particular application.

In this example three-fourths of the heat added to the refrigerant is obtained from the well water and one-fourth by conversion of energy used driving the compressor. This relationship of total heat delivered to energy supplied to the compressor is known as the coefficient of performance (CP) and in this case is stated as 4 to 1.

Energy used to drive the compressor has normally been electricity applied in an electric motor. Other means, such as gas engines or steam or hydraulic turbines, would be applicable.

The greater proportion of the heat supplied is, of course, from the well water in the example given. This is normally termed the heat source.

To be ideal a heat source must be constant in temperature and must be available at low cost.

Ground water, such as well water when cheaply available, and surface water or spring water are most nearly ideal when the temperatures thereof are relatively high or not less than 50°.

Air as a heat source is cheaply available but has the disadvantage of great fluctuations in temperature, resulting in control problems and, in many climates, resulting in icing of heat transfer surfaces. Air has been used successfully as a heat source in the southern climates, including California and Florida.

Earth as a heat source has not been established fully, is limited closely in capacity, and is useful probably only in consideration of residential heating.

In a larger installation, such as in institutional work, well water will normally prove the only feasible heat source. Warm lakes, streams or springs, if available, will prove ideal. In all cases, however, it becomes necessary to investigate the effect of the water on corrosion of metals used to convey it.

Application of the heat pump is further closely circumscribed by a number of limitations. Referring to figure 1, reciprocating refrigeration compressors are not available that would make possible room supply air temperature greater than 125°. Centrifugal compressors available can be arranged to provide temperatures as high as 135°.

Thus, heat pump applications are normally limited to air heating or panel heating, such as has become popular during the last decade. Radiator and convector systems do not lend themselves to use with the heat pump, inasmuch as temperatures required for these systems are much higher than those indicated.

Economic feasibility of the heat pump applications is determined on the basis of first and operating costs.

If no cooling load exists that will justify the purchase of the refrigeration equipment, the cases in which the heat pump can be justified to provide heating only are extremely rare, inasmuch as the first cost will be found to be two to three times higher than that of automatically fired fuel burning equipment, such as boilers. This is a comparison of system costs.

If power costs are relatively low, operating cost of the heat pump in large installations may be as much as 50 per cent lower than if conventional fuels were used.

A comparison of the cost of heating with various fuels and the heat pump at indicated power costs for two coefficients of performance (CP) that represent conservative values are shown in figure 3, from which comparisons may be made simply for conditions applicable to individual installations. Unit cost figures traced upward to fuels or coefficient of performance read at the left cost per million heat units of delivered heat. The coefficient of performance in these comparisons should include the cost of the heat source, which may vary widely in individual installations, depending on specific conditions.

Figure 2 illustrates an analysis of heating and cooling loads in a twelve-

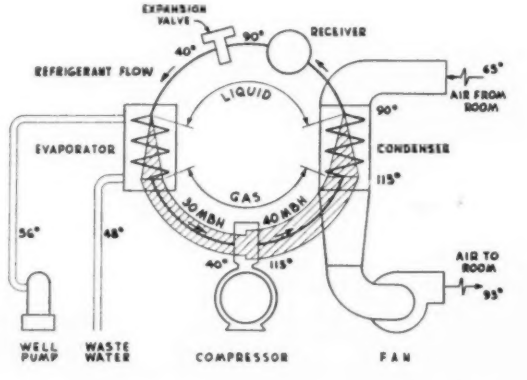


Fig. 1: Diagrammatic sketch of a typical refrigeration cycle used for heating.

BRANCHES IN PRINCIPAL CITIES OF U.S.

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- Rotary Compressor creates spray (this is not a fan-type unit)
- Graphitar lubrication allows unit to run wet or dry
- Clog proof spray nozzle 180° adjustable
- Container withstands chemical action of insecticides
- Precision built to save time and labor and for trouble-free years of service
- Aluminum alloy casting rust resistant
- Low center of gravity for easier handling and aids in preventing unit from tipping over
- Specially built-in fuse assembly protects against burn-outs
- Utilizes every drop of insecticide
- Instantaneous and continuous full pressure spraying
- Density of spray easily regulated by air volume control dial
- Ball bearings hermetically sealed
- No condensation of steam or water to dilute insecticide

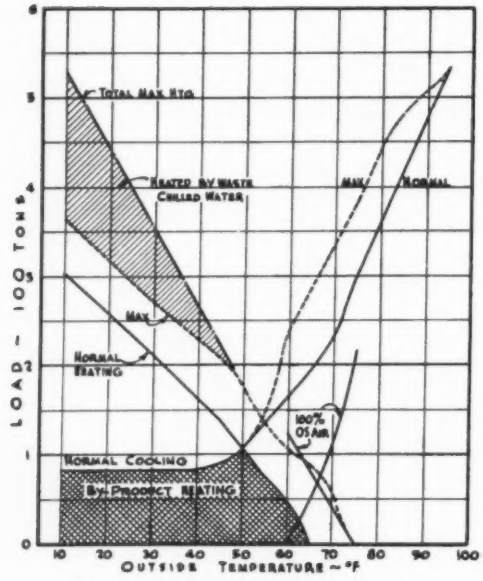
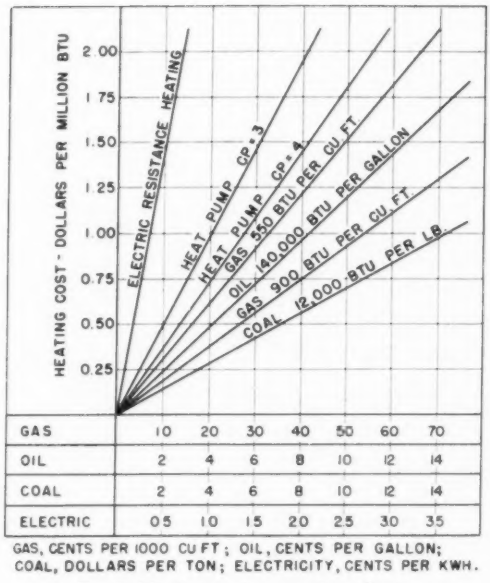


Fig. 2: Heating and cooling load curves.



GAS	10	20	30	40	50	60	70
OIL	2	4	6	8	10	12	14
COAL	2	4	6	8	10	12	14
ELECTRIC	05	10	15	20	25	30	35

GAS, CENTS PER 1000 CU FT; OIL, CENTS PER GALLON;
COAL, DOLLARS PER TON; ELECTRICITY, CENTS PER KWH.

Fig. 3: Heating cost comparison chart.

story Portland office building to which the heat pump, using well water as its source, was applied. In this application, the cooling requirements were as high as those for heating. Values at the left are in equivalent tons of refrigeration, roughly comparable to required horsepower.

Operating costs for heating only are proving from 30 to 35 per cent lower than those available with district steam, used normally in other downtown Portland buildings. A material portion of the heating load is accomplished with waste chilled water and heat recovered from exhaust air. Further, inasmuch as the internal areas of the building require cooling at all seasons of the year, heat is available as a by-product. This low temperature heat is used to temper outside air employed for ventilation when the outside temperature is below 50° F.

This ability of the heat pump to recover heat from substances normally wasted, such as hot waste water or ventilation exhaust air, will in many applications prove economically feasible. This is particularly true in conditioning auditoriums, dance pavilions, student unions, and other such institutional buildings. In many such buildings the heating loads will be reduced by recovery from waste products to an extent greater than is shown in figure 2.

Actually, in many applications the refrigeration equipment provided for cooling will have more than twice the capacity required for heating, if heat is recovered from waste products; and it may be by far lower in operating cost, despite normally unfavorable electric rates. Coefficients of performance (CP in figure 3) on an over-all basis may be as high as 6:1 with heat recovery.

Utilization of the heat pump also is normally favorable in many other services requiring low temperature heating. Institutional examples are swimming pools and dairy products plants.

Heat pump applications have the advantages of providing clean, odorless, sootless heating with no waste products, and no lag. When cooling is required, a saving will be made over a boiler installation if controls are not too complicated. When cooling is required, space saving will result if a boiler is contemplated in addition. An outstanding advantage of the heat pump is the possibility of recovery and use of waste heat, such as that contained in exhaust ventilation air.

Disadvantages of the heat pump lie in its greater first cost if cooling is not required; infeasibility if electrical rates are 1.5 cents per kilowatt hour or greater; limitations of temperatures that restrict its use to central air heating, unit heaters, unit ventilators, or panel type of heating; more painstaking detailed engineering; more expensive and complex control systems because of close temperature tolerances, and problems with respect to suitable heat sources.

Where the cost of power is sufficiently low to result in operating costs appreciably lower than with use of standard fuels, the heat pump should find practical application in many institutions, particularly for auditoriums, other spaces having large ventilation loads, and swimming pools. Under similar conditions, institutional use of the heat pump should find extension in southern climates to administration and other buildings as well.

An example of institutional application of the heat pump is a central heating plant of the Swiss Federal Institute of Technology at Zurich, which employs some 2000 connected h.p. and uses water from the warm Limmat River as its heat source. Installed nearly fifteen years ago, this plant heats some 142 buildings, including eighty-five private structures, and is the largest heat pump application in the world today.

Practicability of the heat pump must be established separately for each proposed application with basic consideration of the heat source, its cost, the heating and cooling loads, and costs of available energy. Load analysis curves, such as figures 2 and 3, must be used and analyzed to establish feasibility.

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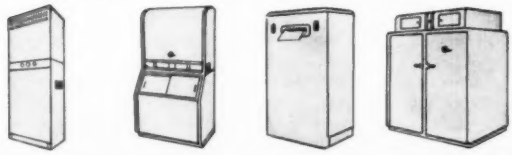
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Boston University Presents —

What the Housekeeper Should Know About PURCHASING

VINCENT W. GODLESKY
Purchasing Agent
Beth Israel Hospital, Boston

PRICE FACTORS IN BUYING

BECAUSE the matter is so important, let us go back for a moment to the factor we discussed earlier relative to prices, namely, that the best price does not necessarily mean the lowest price, or vice versa. To be sure, price is a factor of major importance in any purchase transaction but unfortunately it is too often over-rated in relation to the other considerations that go into making up a sound purchase.

Low prices, without regard to the right quality for example, can result in high maintenance cost or early replacement. The initial price or the invoice price is not always the true price.

Price is only one of the terms and conditions of a purchase order and in itself is meaningless insofar as a good buy or a good value is concerned, unless it is predicated on suitable quality, assured delivery, reliability and continuity of supply, and satisfactory business relations.

To be or to be known as a "price buyer" is not considered complimentary in the purchasing field. It is used in a derogatory sense when it refers to a purchasing agent who buys primarily on the basis of price alone. Being a "price buyer" has other disadvantages besides its uncomplimentary connotation of wanting everything cheap. For example, in periods of short supply and urgent demand, it is unlikely that the "price buyer" will be among the first to be offered the scarce materials. Also, salesmen are reluctant to offer quality merchandise to a "price buyer" when they know that quality is not the primary factor in his purchase considerations.

For those two reasons, among others, it is obvious that a "price buyer" works at a disadvantage to his company not only in connection with obtaining scarce supplies but also in obtaining the best materials or best values available for the most economical and efficient operation of his company.

Low ultimate cost with adequate reference to quality is the objective and responsibility of purchasing. To obtain low ultimate cost, the buyer must have an understanding and appreciation of values, particularly with regard to the products used by his company.

To recognize values, the buyer should know for what purpose he is purchasing a product—what quality of product will adequately satisfy that purpose—and then he must be able to recognize or identify that quality in a competitive market and within a competitive price range.

You may want to ask: How, for instance, do I personally determine what price to pay for a product? My procedure is this: On noncompetitive items we pay the going price, which is usually the list price less a discount allowed to institutions. On small single items whose value is less than the time consumed in getting competitive bids, we buy with petty cash or issue a purchase order at the catalog or specified price. On breakdown repairs or for equipment repairs that must be purchased from the original manufacturer, we pay their price except when the anticipated cost is large enough to require special consideration, or possibly negotiation.

This is the third, and concluding, section of Mr. Godlesky's lecture on the fundamentals of purchasing presented at the housekeeping extension course in Boston

On all competitive items, we obtain at least three competitive quotations from recognized suppliers. This procedure usually gives us a reliable cross-section of the prevailing market prices. On the basis of those quotations, we make our purchase decision —always with reference to the desired quality.

No conscientious buyer has to apologize for requesting and analyzing a quotation. For the most part, sellers respect the buyer who places selling on a truly competitive plane. Of course, all prices should be kept confidential. No respectable firm will care to submit a confidential price if it feels that its bid may be displayed for scrutiny by a competitor.

In the long run, the buyer who obtains competitive bids is less likely to be paying the excessive or out-of-line prices that may be charged to the buyer who unquestioningly selects one vendor, and trusts him to prescribe the right material and to charge a fair price. The classic admonition "Caveat Emptor" (Let The Buyer Beware) was coined for just that type of buyer.

The obtaining of bids and the placing of orders are comparatively simple procedures. All that they involve is the listing of the materials wanted, together with the quantities and specifications. Prices are obtained from salesmen, or by letter, and listed opposite each item and under the names of the selected vendors. Comparison of prices is made and the order is awarded to the lowest bidder—again with reference to quality and conformance to specifications. If there is a great variance in prices quoted for the same item and you are doubtful as to the quality being offered, the surest method of eliminating that doubt is to request samples of the items quoted on. This will afford an opportunity to compare and approve the specifications before placing the order.



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ARMSTRONG'S VEOS WALL TILE

Before placing the order, be certain that you know whether the quoted prices are F.O.B. destination or F.O.B. shipping point. Do they pay the delivery charges, or do you? That difference can often be the determining factor in the placement of your order and in the attainment of low ultimate cost.

In connection with low ultimate cost, attention should also be given to the prompt payment of those invoices which allow a 2 per cent ten-day cash discount. When replacing equipment, look for allowances for trade-ins. These amount to much the same as trade discounts.

The buyer should always watch his P's and Q's, which may be translated to mean his Pennies and Quarters, and his Prices and Qualities. By so doing, he is bound to get maximum values from his purchases, provided he is buying from the right sources, which is the next topic of our discussion.

SOURCES OF SUPPLY

Here, again, I should like to tell you how we select our sources of supply. To begin with, we have a list of suppliers who have been serving us over a period of time. This list includes three or more vendors for each commodity. The advantage of such a list is that immediate sources are available for reference when orders are contemplated. The vendors are chosen with considerable care, not only for the quality and price of the merchandise which they sell, but also for business integrity and, in some instances, for geographical location. This list is by no means closed or fixed. We welcome additional and alternate sources. We endeavor to maintain an open office, *i.e.* any reputable firm that wishes to deal with us is always given an opportunity, and salesmen are always given an interview.

We feel that the salesman is not only a representative of a company but also a person who can lead us to new sources of supply, and who can give us helpful information on many items that we buy. He often knows more about the technical aspects of his product than we do—and is willing to tell us about them. We should always take advantage of those opportunities to learn. It is through such learning that we become better qualified to judge the merits and prices of the materials presented to us.

Whenever possible, we try to establish our sources direct with the manufacturers. It is through direct dealings with manufacturers that worth-while savings are made. Our next preference is the jobber or wholesaler.

It has been said that "no purchasing department is stronger than its suppliers." The truth of that statement was demonstrated during the recent period of stress and scarcities and should be a lesson to us in selecting reliable and dependable sources of supply. We select vendors who we feel can deliver the right quality at the right price and will be able to give us continuous service under all conditions. Manufacturers, jobbers and wholesalers of long standing in business are usually best qualified to meet those requirements.

Selecting a source of supply on the basis of a salesman's statement that other institutions are using his product is not a sound or scientific procedure. It does not necessarily follow that because a certain product is acceptable to other institutions that it will fulfill your requirements equally well. Physical plant conditions or standards of service at other institutions may justify their use of certain products, whereas your requirements may or may not be satisfied by the same product or products from the same source. Therefore, it is the responsibility of the buyer and his associates to determine the suitability of products for their own use and to decide on the advantages that may be derived from dealing with certain suppliers.

At present, we are in a buyer's market. Sources of supply should not be a difficult problem. Plenty of salesmen are out looking for business. However, if the buyer should have occasion to look for sources, there are a number of mediums available. For local sources of supply, there is probably no better medium than the classified section of your telephone directory. Of course, your local newspapers should not be overlooked, or your contacts with members of your own housekeepers' association. These people can be extremely helpful in this respect.

For out-of-town sources there are vendors' catalogs and direct mail literature. Also there are the hotel and hospital publications which carry advertisements directed to hotels and hospitals.

Visiting the exhibits at hotel and hospital conventions is another excellent means of learning of sources of supply. These visits also provide an opportunity to see many new products and to witness demonstrations of their use.

Still another source of supply, particularly for hospitals, is the Hospital Bureau of Standards and Supplies. This is a nonprofit cooperative buying organization. It is supported by membership dues from more than 200 hospitals throughout the country. Its purpose is to serve as a reliable and impartial reservoir of information and assistance on buying matters and to do sufficient buying to set up yardsticks on quality, price, suitability and sources of supply to guide and implement the efforts of its member institutions.

It is appropriate to conclude this discussion on purchasing by reemphasizing the need for the application of scientific purchasing principles in the hotel and hospital fields. The buyer who continues to use horse-trading tactics cannot, in the long run, obtain the best service and the economical values that his organization has a right to expect. To perform the purchasing function properly, the buyer must make use of technical skill and scientific methods in selecting the products he is purchasing.

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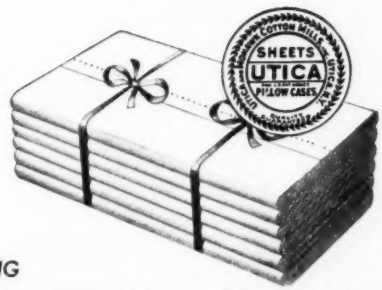
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NEWS DIGEST

Southeastern Hospital Conference

By Everett W. Jones

BILOXI, MISS.—Voluntary hospitals disappear from countries where compulsory health services are introduced, Joseph G. Norby, president of the American Hospital Association, declared at the 12th annual assembly of the Southeastern Hospital Conference here last month. More than 750 hospital people attended the conference; in addition to administrators, trustees and auxiliary members, the group included affiliated associations of anesthetists, pharmacists, medical record librarians, dietitians and related technical and professional personnel.

"In subsidizing hospitals, the state is not playing Santa Claus," Mr. Norby warned. "Rather, it expects something in return." The hospital board holds its trusteeship on behalf of the community and cannot surrender its sovereignty to anyone, since the hospital is a public necessity and community agency, he concluded.

At another meeting, Dean Conley, executive secretary of the American College of Surgeons, urged hospital administrators to make certain that an adequate "understudy" was being trained for each department head in the hospital. This "second line" personnel is necessary, Mr. Conley said, because hospital service must not be left at the mercy of any one individual.

Voluntary hospitals are overlooking a good thing when they fail to organize and encourage active women's auxiliary groups, Mrs. Garrison Elder, president



Left: Dr. D. V. Galloway, director, Mississippi Commission on Hospital Care; right: Lester Tuck, assistant director.



Mrs. Jewell Thrasher, Southeastern president, with President-Elect James Crews. Standing: Burton Battle, past president.

of the auxiliary group at the Baroness Erlanger Hospital, Chattanooga, Tenn., told the conference. Some 500,000 women are now working in auxiliary programs throughout the country, Mrs. Elder said. She reported that membership in the national organization of hospital auxiliaries doubled since the program was undertaken a year ago.

If auxiliary members are thoroughly educated and properly organized, Mrs. Elder said, they can transmit hospital facts and interpretations to the public better than any other group in the community. Women in most places are eager to take part in organized auxiliary groups, she said, and are always especially interested in hospital work. At the conclusion of the conference, the group followed Mrs. Elder's suggestion and organized an auxiliary section to the Southeastern Hospital Conference which will meet annually at the time of its assembly.

When appropriate supervision and control are available and effective, the "open staff" hospital organization is probably best from the standpoint of medical care for the whole community, Dr. Malcolm T. MacEachern of the American College of Surgeons declared at one of the assembly meetings. The closed staff, while it may afford a measure of protection to hospital patients, means that a certain number of doctors in the community are excluded from the hospital and fail to get the educational advantages of association with other staff members, he explained. Patients of these doctors are likely to get poorer care as a result of the lower standards that prevail outside the staff organization, it was pointed out.

Carolinas-Virginias Hospital Conference

Contributed by C. T. Loftus

ASHEVILLE, N.C.—The dispute about socialized medicine was featured at the 19th annual Carolinas-Virginias Hospital Conference here last month when Dr. G. Westbrook Murphy of Asheville, president-elect of the North Carolina Medical Society, and Mrs. May Thompson Evans of the Federal Security Administration debated the national health insurance question at the opening assembly of the conference.

Mrs. Evans charged that opponents of the national health program, favored by the administration, are using "an evil-sounding catch-phrase, 'socialized medicine,'" as a false charge to defeat a measure that is needed in the interest of national health. "The false charge of socialism will never permanently defeat health insurance," she declared. "Discussions I have had with members of the medical profession on the issue of health insurance have created in my mind a marked distinction between the official leadership of the American Medical Association on the one hand and many of the doctors who comprise its membership on the other. Many doctors are honestly opposed to the health insurance program because of their fear that the effect would in the long run be detrimental to the practice of medicine and the national health. Many others are troubled by doubts. But many of these same doctors have little patience with the arguments and tactics of the American Medical Association."

Answering on behalf of the medical profession, Dr. Murphy characterized the drive for socialized medicine in the United States as a "political maneuver

(*Continued on Page 124.*)

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NEWS...

Texas Hospital Association

Contributed by Ruth Barnhart

GALVESTON.—Rain, ice and hail did not prevent a record-breaking attendance of delegates to the annual convention of the Texas Hospital Association here last month. Registration totaled 558 in the hospital sessions, 53 medical record librarians, 60 nurse anesthetists, 56 women members of hospital auxiliaries, and 251 representatives displaying the products of their firms in 104 exhibit booths—more than a thousand all told.

Dr. Warren T. Brown of Baylor University Medical College emphasized the need for continual awareness of how the hospital came about, of its objective, of what it contributes and of how it fits into our present culture. Our public rarely looks at the hospital; he accepts it as a part of his culture, Dr. Brown said. But he wants to know these other things about it, too. The traditional flexibility and willingness of hospitals to respond to the continually changing needs of the patient, "who plays the leading but unrehearsed rôle in the drama of the hospital," will permit public assurance that the hospital is doing its job, he concluded.

Hospitals enjoy a considerable advantage in that almost anything they do is of interest and concern to the newspaper reader, John T. Jones Jr. of the *Houston Chronicle* told the convention. He urged a broader delegation of authority, or at least an established chain of authority, to assist the press in presenting timely news to the public; to provide needed cooperation in presenting reliable, factual reports on prominent people when they are patients in the hospital, and to squelch incorrect rumors. "Cooperate with the newspaper man; he can help you immensely," Mr. Jones stated. "If you can't answer his questions, explain why, but don't give him the brush-off."

A.H.A. President Joseph G. Norby predicted that the patient of the future will need and probably get a higher order of care than the patient of the past, because the demands of modern medicine will make it necessary and because we gradually are getting a better understanding of what is involved in nursing. The quality and quantity of nursing care will depend on the cooperative efforts of all groups involved —hospitals, nurses, the medical profession, and the public, Mr. Norby said.

An event was initiated this year which probably will be repeated each year from now on—an exhibitors' breakfast attended by representatives of each exhibiting firm and the officers and trustees of T.H.A. This meeting was established for the exchange of ideas and suggestions to improve the convention program and exhibit arrangements. At the banquet which was the final event of the convention, Dr. D. M. Wiggins, president of Texas Tech in Lubbock, warned against over-specialization in every field of endeavor. There is danger, he said, that a man can no longer be fully educated to appreciate and understand the efforts of people in other fields, but must put every thought and moment to his own particular job.



Roy Wilmesmeier, president-elect of the Texas Hospital Association, administrator, Southern Pacific Hospital, Houston.

Carolinas-Virginias . . . (*Continued From Page* 122.)

which is part of a plan to create a welfare state and force our country into socialism." There is no spontaneous desire for state health care among the people, Dr. Murphy insisted. Nevertheless, he said, "our federal government in violation of law is spending large sums of money in a campaign to discredit the medical profession and create an artificial demand for socialized medicine."

Following these and other talks, including an explanation by Executive Director George Bugbee of the American Hospital Association's program of favoring federal aid for voluntary health insurance plans, the conference passed a resolution endorsing the voluntary health insurance bill recently introduced in the United States Senate by Senator Hill of Alabama. The bill was characterized in the resolution as a "significant reinforcement of a highly successful voluntary effort by the American people to provide health protection for themselves."



Head table, Texas banquet, l. to r.: Mrs. Frank Dent; Dr. L. L. D. Tuttle; Laura Hoffman; Mrs. C. H. Hollingsworth; D. M. Wiggins; Mr. Hollingsworth; Rev. Frank Dent; Julian H. Pace; Mrs. Tuttle; E. C. Hayhow; Clara Schwabe, and Dr. W. W. Nesbit.

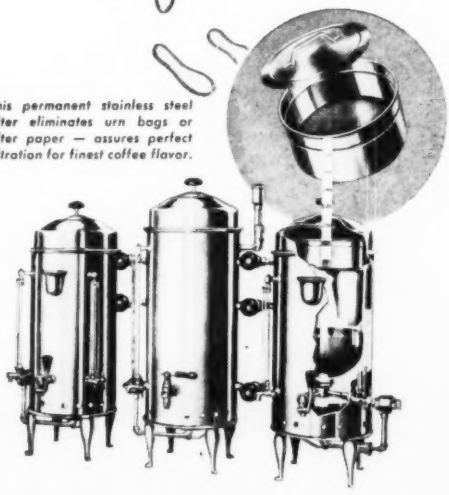


Ralph Bryan, A.I.A., speaks on hospital construction at round table session. Other panel members were, l. to r.: Hamilton Brown; Walter R. Rolfe; William R. O'Connell; Norman B. Roberts; J. Richard Gates, and H. R. Dickey.

clue



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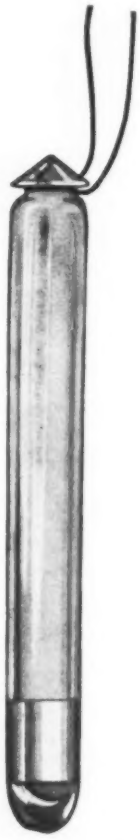
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NEWS...

Tri-State Assembly

(*Continued From Page 64.*)

the government to do for people what they cannot do for themselves." Insists that hospitals are so far in soup already that they will drown without government assistance. Says: "Social Security does *not* lead to socialism; it relieves pressures that lead to socialism."

Dr. Fishbein, on opposite shore, does not agree that medical and hospital care in such parlous condition that they have to be taken over by government. Medical leaders have not resisted change; they have created change! Inadequacies in medical care do exist. A.M.A. urges better pay for public health personnel; urges proper place for government in rendering financial aid, but not control. But if we want financial aid we have to stand for what government aid requires.

A.M.A. got behind Hill-Burton Act because method of payment controls standards. Harped on change brought about by scientific advancement rather than method of payment. A.M.A. is "supporting voluntary plans because they are *now* delivering." Urges wide development of voluntary insurance. Is there evidence that President's bill will give better care? No. A.M.A. will encourage every voluntary effort, will cooperate with government that *will* cooperate and not stand stubbornly and say "You must do it our way or else."

Nursing: Bitter history repeated itself at nursing meeting, inappropriately called "joint conference of hospital administrators and nurse directors." Nurses out in full force to sell administrators on the nursing team, but administrators were out shopping in some other street apparently.

Democracy is making slow and quiet advances in nursing. The team system of patient care, as envisioned in the paper read for Lucy Germain of Detroit's Harper Hospital, is one avenue of democratic approach. All team members can be allowed to make suggestions and have the satisfaction of seeing their better ideas carried out.

Student nurse fits logically into nursing team only if she is used correctly, contended Harriett R. Berger, instructor-supervisor at St. Luke's, Chicago. Her duties must be properly assigned and her experience zealously guarded.

General Observations: Too many people in same place. Rooms small, hot, crowded—or so big (like grand ballroom) audience is lost (personnel section Monday afternoon) and speaker looks lonesome.

Contributed by Carl D. Rinker

Student Section: Fred P. Ryder, Washington University, said that each month a different student acts as group leader and arranges and conducts all field trips. Simulated board meetings are conducted to give student experience in selling ideas to future boards of directors. Department heads from Barnes Hospital sit in and stimulate comment. Current group leader acts as board chairman. General belief at Washington is that supplementation of formal study with field trips and extracurricular activities is necessary to round out student for administrative post.

Richard L. Johnson, University of Chicago, believes field trip should be designed as a necessary supplement to theory and that timing should coordinate the trip with time applicable theory is being studied. Believes trip should be planned sufficiently in advance to permit administrator to plan successful demonstration. Believes administrator should be given complete information as to why students are making trip. Student should approach trip with question "What can I learn that will make me a better administrator?"

John W. Etsweiler, Northwestern University, explained function of hospital club and fraternity. Presentation of papers to fraternity on professional level. Panel programs of hospital club, hospital club mixers, weekly field trips. Visits to industrial plants (Lilly, Johnson & Johnson). Stressed need for balance between formal study and extracurricular events.

Ralph M. Hueston, administrator, Wesley Memorial Hospital, stressed point that hospitals will in future benefit from excellent training being given students now. Believes in importance and necessity of field trips as a supplement to formal education. Believes they should be handled as follows:

1. Representative from school should discuss projected trip with administrator well in advance. Administrator should contact applicable dept. head and set up trip.
2. Trip should be confined to one subject.
3. Small groups best.
4. Do not permit any waste time or any lag in demonstration.
5. Administrator or one of his staff should be demonstration leader.

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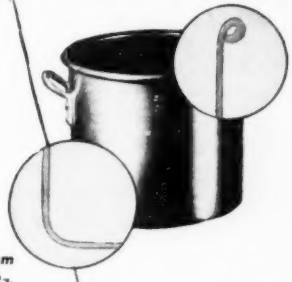
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6. Should open demonstration with short explanation.

7. Demonstration should be thorough but not of great length.

8. Demonstration should be followed by a thorough round table discussion of the things just seen. Each student must participate in the discussion. If possible the same area should be observed in more that one hospital under different conditions. Believes that field trips prepare students for future responsibilities.

Ray E. Brown, University of Chicago Clinics, believes that value of field trip depends on value as a teaching technic, based on amount of time allowed for student's academic work. Believes that importance of putting message across to students in short academic year precludes use of trips and tips scales in favor of spending time on theory, leaving demonstrations to year of residency. Questions using time to put "polish" on students. Believes that polish should be there when student is accepted as such. Is in agreement with Mr. Hueston as to conduct of field trip. Believes that trips should be designed to show students conditions which are not ideal.

Floor discussion lively and controversial regarding benefits to be gained from field trips. Consensus was that properly planned field trips are desirable method of teaching.

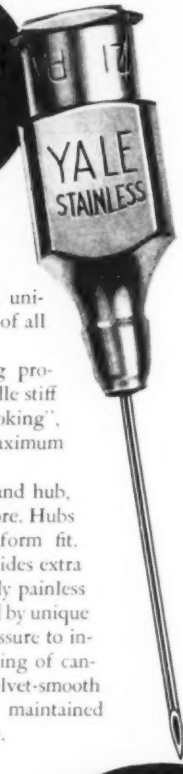
Contributed by Merton E. Knisely

Small Hospitals Section: Andrew Pattullo spoke about conduct of medical staff meetings. In many small hospitals they are combined with the county medical society, thus minimizing the real scientific efforts of the hospital's medical staff. Staff frequently takes up many matters routinely, particularly deaths for the month, which again minimizes true scientific effort. He pointed out the success of staff meetings and clinical conferences in small hospitals where sincere effort had been made by the chief of staff and one or more other officers to plan and select the material carefully. He emphasized the medical audit and suggested use of consultants from outside the hospital to help evaluate results.

Carl Lamley talked about atmosphere in which hospital employes work as it determines whether they are happy, satisfied and encouraged to lend their best efforts. He pointed out that the best training for an employe was the example set by the supervisor or the administrator, that by all odds this was one of the greatest factors in encouraging harmonious relations and in training personnel.

Gerhard Krembs emphasized accounts receivable and the necessity for keeping them in good shape. He told how he had obtained government payment at full cost, how the auxiliary was helping to purchase several items of equipment, and how insurance policies taken out by members of the community were accruing to the hospital in the future.

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NEW YORK.—Dean Margaret Bridgman of Skidmore College has been appointed to the Russell Sage Foundation staff as a special consultant to universities in the field of nursing education, it was announced here last month. The appointment will be for a period of about two years, during which Dean Bridgman will be on leave from her college duties, Dr. Donald Young, foundation director, stated.

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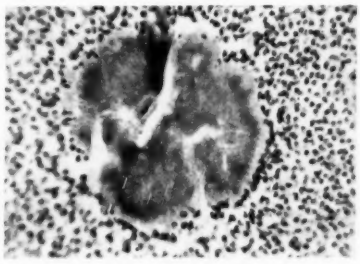
Nor are photographs like these difficult to obtain. All that's needed for brilliant visual records (color or black-and-white) is a camera (almost any view type will do), a reliable light source, a supply of Kodak Film.

In fact, the full-color photographs reproduced on this page and the following were all made with simple, easy-to-use equipment in standard lighting arrangements—setups which, once established, could be duplicated readily.

Kodak Flasholder is held 2 feet above camera and 30° to camera-subject axis. Three-foot extension cord permits synchronizing with Kodak Flash Supermatic Shutters at 30° angle.

Words could never tell the story of this hemangioma as quickly and effectively as this color photograph. Yet it was made easily . . . and in less time than it would have taken to write the complete case history.





LEFT TO RIGHT: *Photograph of area of granulation tissue at edges of extraction wound. Photomicrograph of* **Actinomyces israeli** *in biopsy specimen from region such as at left.*

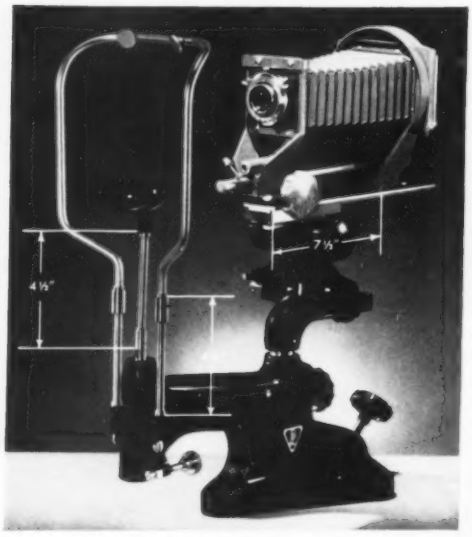
AID TO DIAGNOSIS: *With color transparencies such as these, the physician can scrutinize cases at his leisure . . . review his findings again and again. He can consult with associates, in person or by mail . . . obtain the opinions of others, wherever they are.*

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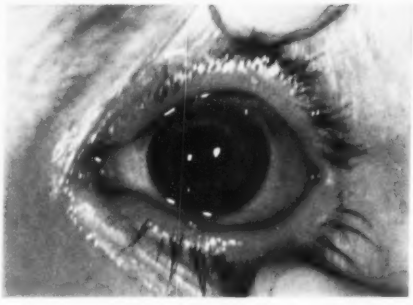
Picture the patient's progress (*continued*)



SETUP FOR EYE PHOTOGRAPHY: *Provides for accurate vertical, horizontal, and lateral adjustment. With components shown, 2¼ x 2¼-inch color or black-and-white photographs may be made; also, with an adapter, Bantam and 35-millimeter sizes.*



PREOPERATIVE PHOTOGRAPH (TOP): *Traumatic cataract recorded with 35-millimeter setup similar to improvisation at left.*



POSTOPERATIVE PHOTOGRAPH (BOTTOM): *Identical positioning and exposure factors afford basis of comparison.*

Most cameras become "color cameras"

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16-millimeter motion-picture cameras use Kodachrome Film in rolls or magazines . . . give duplicates for brilliant showings.

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Miniature cameras, most of them, use Kodachrome Film . . . give slides for projection, prints, enlargements.

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X-ray films; x-ray intensifying screens; x-ray processing chemicals; electrocardiographic papers and film; cameras—still- and motion-picture; projectors—still- and motion-picture; enlargers and printers; photographic films—color and black-and-white (including infrared); photographic papers; photographic processing chemicals; synthetic organic chemicals; Recordak products.

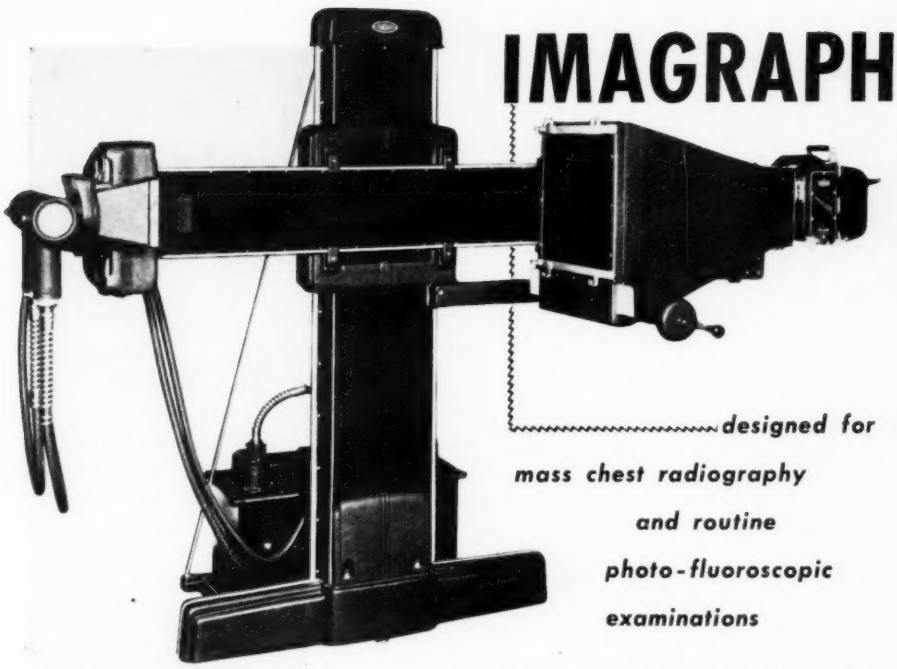


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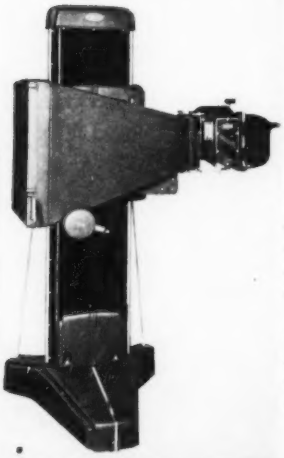
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NEWS...

Mid-West Convention

(*Continued From Page* 65.)

instead of industrial antagonism." What is true in industry well may be applied in the hospital field, the speaker added. He urged a well rounded program of human relations to solve hospital personnel problems.

The importance of human relations as they affect hospital employes was also stressed by Clarence E. Copeland, superintendent, Missouri Baptist Hospital, St. Louis, in his address on "Personnel Relations—Majoring in Morale Building."

"Personnel is not a part of the hospital, it *is* the hospital; to develop a strong, happy, loyal, cooperative personnel is the heart of our problem, for manpower in the final analysis is our only enduring asset," declared Mr. Copeland. "It is necessary to understand clearly that loyalty and cooperation are spiritual dynamics. Loyalty and cooperation must be freely, voluntarily and willingly given by the employe. We cannot buy loyalty with higher wages, nor can we force it by any other means; the desire to be loyal and cooperative must originate in the mind and heart of the individual employe himself. This is the pearl supreme—the priceless ingredient of good administration."

The American College of Surgeons' standardization program in its relation to small hospitals was outlined by Celeste K. Kemler, R.N., administrator, Valley View Hospital, Ada, Okla. "The minimum standard requirements can be applied to the small hospital; in fact, they are necessary in establishing proper organization and administration to care efficiently for the sick," said the speaker.

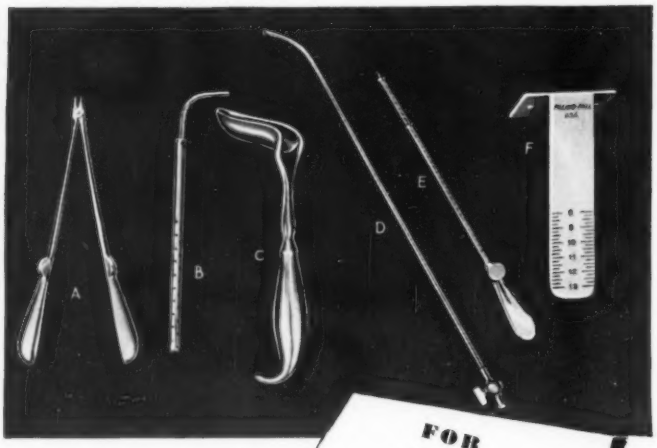
Catherine Maloy, New York City, director of hospital services of the National Foundation for Infantile Paralysis, outlined a plan for the care of polio victims in the rural community and the small hospital at the general session and also spoke on "Polio Preparedness" at a sectional meeting dealing with the disease.

Expansion of voluntary hospitalization insurance plans, led nationally by the companion Blue Cross and Blue Shield plans, with federal government assistance in defraying premium costs for the low income groups, was the alternative offered by George Bugbee, executive director of the American Hospital Association, to the proposed tax-supported national health system which currently is being urged before Congress by President Truman. A continuation of federal aid for the construction of new hospitals in communities now without such facilities, which would permit local hospitals to remain as community enterprises rather than come under federal control, also was advocated by Mr. Bugbee, who spoke several times during the convention.

In discussing the socialized medical program in England, Mr. Bugbee commented that "the compulsory health program in Great Britain is still in the 'honeymoon stage' and that the average voter is favorably disposed to the project." However, a bill now before Parliament to provide a deficiency appropriation to defray the rapidly mounting costs of the program soon will awaken the average voter-taxpayer to a realization of the manner in which the "free" medical care program will affect him personally through the medium of tax assessments to maintain the system.

Richard M. Jones of Chicago, director of the Blue Cross Commission, told the audience of the spectacular growth

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NEWS...

of the Blue Cross movement, from a membership of 3,000,000 to 33,000,000 within a period of 10 years. Mr. Jones discussed the relations between Blue Cross and its subscribers as well as the hospitals.

Leonard P. Goudy, American Hospital Association purchasing specialist, and Hubert W. Hughes, business manager, St. Anthony Hospital, Denver, "played to a full house" in an overflow sectional meeting devoted to a discussion of purchasing problems. Mr. Goudy discussed standardization and simplification programs of the A.H.A., and Mr. Hughes spoke on the receipt, storage and issuance of hospital supplies. In the sectional conference on retirement plans for hospital employes, representatives of the National Health and Retirement Association reported on recent developments of the A.H.A. pension program, under which 27,000 hospital employes are now enrolled, and the effects of the proposed expanded federal social security program in relation to the A.H.A. project.

A word of caution, that improvement of hospital administration be considered as a means of rendering better care to patients rather than in the light of strictly evaluating hospital administration by the same economic and financial criteria used in judging business enterprises, was issued by Rev. P. A. Flanagan, S.J., St. Louis, in his address which featured the public luncheon meeting on the second day of the convention. Two hundred administrators overflowed the confines of the Hotel President's Aztec Room to hear the popular executive director of the Catholic Hospital Association.

"We must improve our management technics and strengthen business control, but we also must not forget that we are engaged in the basic Christian activity of rendering personal care to people who are sick. Regardless of our problems of management, the patrons of our institutions have a right to look to us for the human Christian qualities of kindness, sympathy, patience and charity; they have a right to be treated as personalities, not mere numbers or cases on an assembly line in a system of mass production," Father Flanagan told his audience.

Licensure, consultation, accrediting, interpretation and preparation of source materials were listed as current objectives of the program of the National

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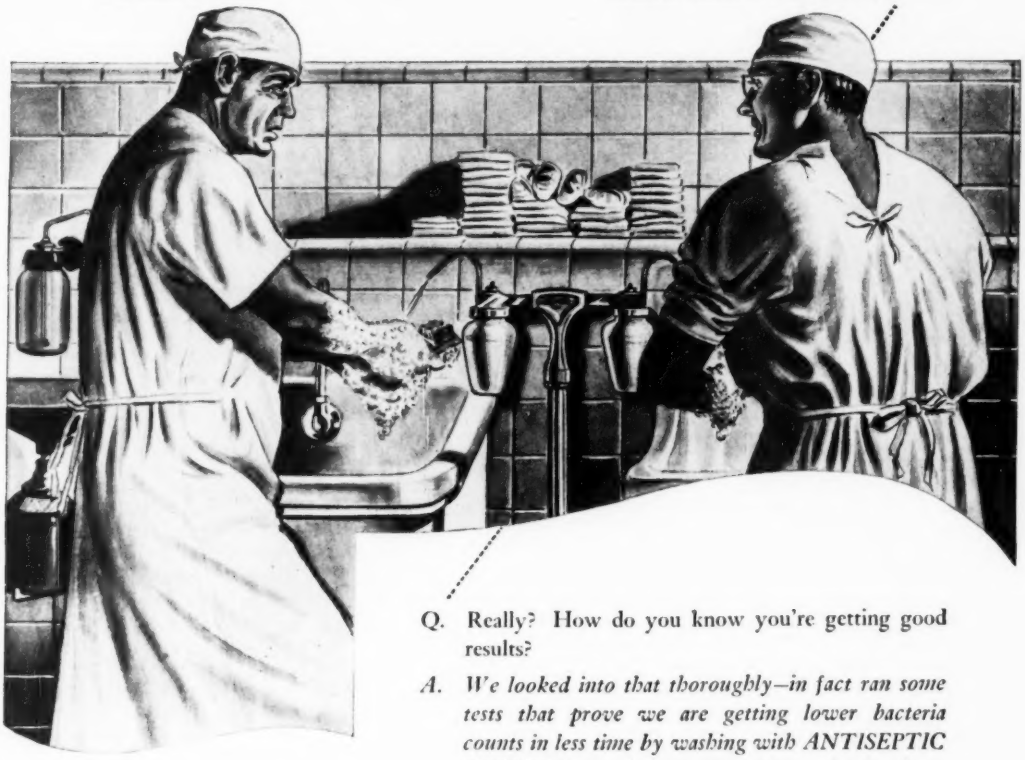
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Q. Really? How do you know you're getting good results?

A. We looked into that thoroughly—in fact ran some tests that prove we are getting lower bacteria counts in less time by washing with ANTISEPTIC SEPTISOL regularly—even without the brush or alcohol.

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A. That's right, and the beauty of it is that it's not harsh on the hands. We haven't had any trouble with irritation since we have standardized on it.

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NEWS...

Association of Practical Nurse Education by its executive secretary, Hilda M. Torrop of New York, in the professional personnel sectional meeting. Dora B. Ford, R.N., assistant director of nurses of Missouri Pacific Hospital, St. Louis, outlined essentials in planning a program of education for practical nurses. Miss Ford stressed the necessity of a survey of needs and resources in the community before such a program is undertaken. Important steps include a well laid public relations program, proper sponsorship, satisfactory financing, sufficient teaching personnel, securing of equipment and library facilities, and effective policies.

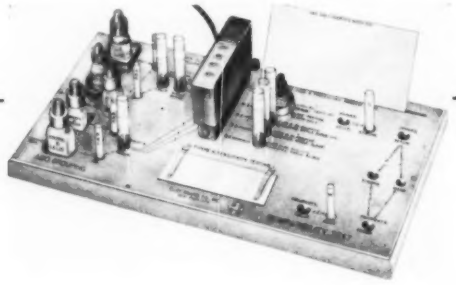
In presenting the economic security program of the American Nurses' Association, Thelma Laird, R.N., associate executive secretary, stated that if the nursing profession is to survive, it must restore nursing to advantageous competition with other professions for qualified recruits. Unsatisfactory employment conditions constitute one of the most serious obstacles which must be removed and it was to correct this situation that the economic security program was instituted in 1946, she said. "Collective action is the appropriate and only effective means of improving the economic status and employment conditions of nurses and the professional association is the preferred representative of the nurses in the implementation of their economic goals," the speaker declared. She urged hospital administrators to accept the program and "respond with enlightened cooperation."

Answering on behalf of hospital administrators, Harry J. Mohler, St. Louis, president of the Missouri Pacific Hospital Association, acknowledged the right of nurses so to conduct their activities. However, he challenged, they must be prepared to face realities in the proper care of the sick and to organize their members into two divisions, supervisors and workers, so that hospitals can be staffed properly the clock around.

A symposium on hospital construction and expansion programs brought Douglas N. West, U.S.P.H.S. staff member in Washington, and state program directors Moody Moore, Little Rock, Ark.; Verne A. Pangborn, Lincoln, Neb.; Herbert W. Moe, Denver; Roy Johnson, Topeka, Kan., and Ida R. Gutschke, R.N., Springfield, Mo., for the program. Proposed bills for expansion of the federal aid program under Public Law 725, if passed, will increase government grants from 10 to 20 per cent over the present 33 per cent participation, several said.

Cautioning that legal problems in small hospitals do not differ essentially from those in larger institutions, Emanuel Hayt of New York urged that administrators in small hospitals be ever on the alert with regard to the quality and degree of care to the patient; that adequate by-laws, rules and regulations be adopted and that they be reviewed regularly and kept up to date. "Smaller hospitals should take an active part in shaping legislation by working closely with their state associations. Administrators should see that they are assisted with legal problems by competent counselors. The avoidance of legal complications through early and expert help, like preventive medicine, is likely to prove less costly and more beneficial in the long run," he concluded.

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1. "A Note on Blood Grouping and Cross Matching with Special Reference to a Convenient Grouping Cross Matching Board." I. W. Brown, Jr., M.D. In press.

2. "The Demonstration of Anti-Rh Agglutinins An Accurate and Rapid Slide Test." L. K. Diamond, M.D., and N. M. Abelson, M.D. Jl. Lab. & Clin. Med., Mar. 1945.

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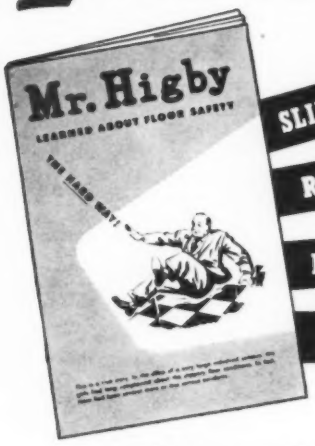
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M-A4

NEWS...

vised administrators to be watchful, particularly in the preparation of the hospital's insurance requirements. Adequate insurance provides protection through a well balanced program, including extended coverage, temporary occupancy, boiler and machinery coverage, sprinkler leakage, plate glass, surety bonds, motor vehicles and the usual public, professional, elevator and workmen's compensation liability coverages.

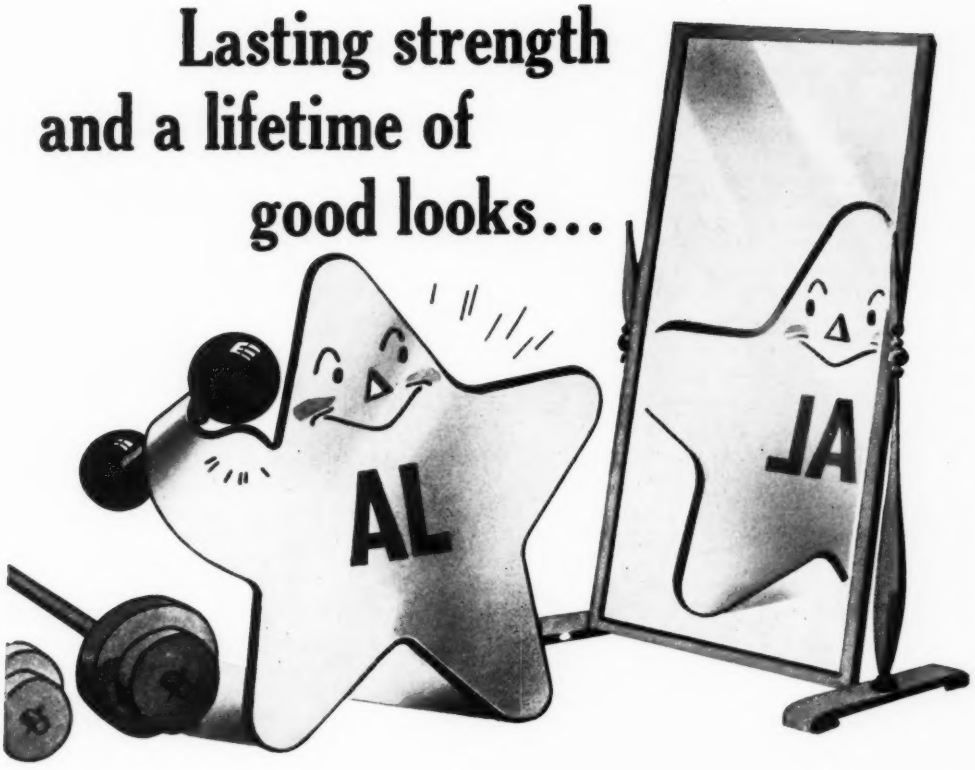
The annual banquet, Wednesday evening, was featured by the induction of newly elected officers, with Bert Caldwell, retired executive secretary of the American Hospital Association, conducting the installation ceremonies. Awarding of a plaque to St. Anthony's Murdock Memorial Hospital, Sabetha, Kan., for the best community public relations programs within the Midwest territory during the last year was announced by retiring president Regina H. Kaplan. An engraved plaque, in recognition of Miss Kaplan's services during the last year, was presented to her by Mr. Caldwell.

Iowa Hospital Group Names New Officers

DES MOINES, IOWA.—Sister Mary Eileen, administrator of the Mercy Hospital, Cedar Rapids, was named president-elect of the Iowa Hospital Association at the association's annual meeting here last month. Sister Mary Eileen will succeed Nelle Lundy of the Cedar Valley Hospital, Charles City, Iowa.

Other officers elected by the association were: first vice president, R. R. Hobart, Iowa Methodist Hospital, Des Moines; second vice president, T. P. Sharpnack, Broadlawns Hospitals, Des Moines; treasurer, F. A. Hanson, Lutheran Hospital, Des Moines; secretary, Mrs. Rose Jacobs, Skiff Memorial Hospital, Newton; board of trustees, Gerhard Hartman, University Hospital, Iowa City, Rubie M. Carlson, Allen Memorial Hospital, Waterloo, Harold K. Wright, Methodist Hospital, Sioux City, Harold A. Smith, Atlantic Memorial Hospital, Atlantic; delegate to American Hospital Association House of Delegates, Harold K. Wright, Methodist Hospital, Sioux City; alternate, Mrs. Grace Heller, Sioux Valley Hospital, Cherokee; delegates to Upper Mid-West Conference, Gerhard Hartman, University Hospital, Iowa City, and Harold K. Wright, Sioux City.

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NEWS...

Western Hospitals

(*Continued From Page 65.*)

able to prepare nurses as specialists in the various fields of hospital nursing while there are relatively many scholarships for fields like public health which take nurses out of hospitals.

Every step in the advancement of nursing, she said, needs the help and cooperation of hospital administrators if it is to be successful.

The use of practical nurses was, of course, covered, an able paper on the subject being presented by Sister John of the Cross, Portland. "Five years ago none of us would have believed that the idea of practical nurses could have obtained as widespread support from professional nurses in so short a time," she said. Instead of opposing practicals now, the professional group is reaching out vigorously to control them through licensure and setting of standards.

In the discussion period an overwhelming majority of the audience of nurses and hospital administrators favored some form of licensure of practical nurses but a considerably smaller majority favored compulsory licensure of all who nurse for hire. Sister John of the Cross strongly supported licensure as a protection to the public, the practical nurses themselves and the hospitals.

The "health team," consisting of doctor, professional nurse, practical nurse, dietitian and other specialists as needed, was a concept stressed by many speakers.

The audience was warned by George Wood, Oakland, not to accept anyone else's ratios of practical nurses to professional nurses until a careful analysis has been made of the jobs each is to do and the quantity and type of patients the hospital is to serve.

A debate on inclusive rates was rather inconclusive. Dr. J. A. Katzive, San Francisco, presented the arguments in favor while Frank J. Walter, Portland, argued against them, but the lack of definition of terms prevented a real meeting of minds.

The case for a guaranteed minimum annual salary was presented by Richard A. Liebes of the Building Service Employees Union, San Francisco, while the case against was offered by Robert Littler, labor relations attorney, San Francisco. The clinching argument against such guarantees was made in the minds of most hospital administrators when Mr. Liebes admitted that the unions themselves did not have such arrangements with their own employes.

The federal reimbursable cost formula came in for some vigorous criticism of details from both Dr. Marcia Hayes, representing the government, and Henry X. Jackson, assistant administrator, Herrick Memorial Hospital, Berkeley, representing the accountants. Both agreed, however, that the basic formula was good.

Improvements suggested were: (1) removing all arbitrary ceilings on rates, (2) paying more for short stay cases than for long stays, (3) adjusting retroactively to changes in costs, (4) simplifying of reports, (5) speeding up payments, and (6) leaving patients in the hospital where first treated as long as treatment is needed.

Jessie J. Turnbull, A.C.H.A. president, announced that more than $100,000 had been pledged to the college's drive for a $425,000 educational fund. Western members generally seemed to be in favor of the program.



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If you are considering an appeal to the public for funds, we would be pleased to have our representative call without obligation to explain our services and their cost.

An illustrated brochure, "Your Appeal to the Public," explaining the professional direction of fund-raising campaigns, is available upon written request to Department F-6.

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NEWS...

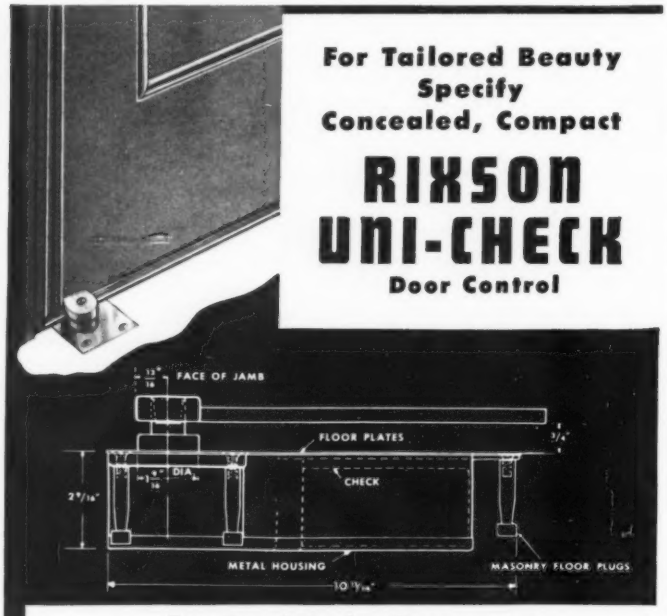
The need for added hospital facilities is being substantially reduced by new developments in chemotherapy and early ambulation technics, according to Dr. Lowell Rantz of Stanford, Ritz Heerman of Los Angeles and Dr. Gerson R. Biskind of Mt. Zion Hospital, San Francisco. But the saving on bed space is needed for more laboratory, treatment and all other types of service areas, Mr. Heerman pointed out.

Infant diarrhea in nurseries was laid by Dr. Henry Bruyn of the University of California to (1) bacterial pathogens, (2) virus diseases or (3) a third cause which is assumed to be massive bacterial contamination with organisms of low pathogenicity. Carelessness of nurses, doctors and other personnel is the greatest hazard to the newborn so far as the third category is concerned, but outbreaks in the other two categories frequently hit the most careful hospitals and miss those which are least careful, according to Dr. W. W. Stadel, San Diego County Hospital.

Safe formulas for newborn require (1) good clean preparatory technic, (2) proper terminal heating of the entire assembled unit including the cap by either pressure or nonpressure technic, (3) efficient preliminary precooling, (4) adequate refrigeration, (5) periodic control checks, and (6) intelligent supervision at every stage.

A diamond pin was presented to Dr. Malcolm T. MacEachern, honorary president of the Association of Western Hospitals since its founding. "Mac" has never missed a meeting of the association in its 19 year history.

Blue Cross was extensively discussed and compared with the clumsiness and inefficiency of government in the hospital and medical field. E. A. van Steenwyk pointed out that government has had responsibility for care of the veterans, the Indians and the mentally ill and in no case has it a distinguished record. In these fields it has been unhampered by competition yet the results are generally considered shameful.



Break Ground for New Greenwich Hospital

GREENWICH, CONN.—Ground was broken here last month on the new $3,500,000 Greenwich Hospital, William Donnelly, administrator of the hospital, reported. About 100 hospital workers, public officials and others attended the ceremonies, Mr. Donnelly said, including members of the governing board and hospital corporation, medical and hospital staffs, nurse alumni and women's auxiliary groups. Edward K. Warren, president of the hospital, expressed the appreciation of the board to members of the community for the support which has made the new project possible.

N.Y. Plan Has "Largest Gain"

NEW YORK.—Enrollment of 275,676 persons in New York's Blue Cross plan during the first three months of 1949 represented the largest gain for any calendar quarter in the organization's history and brought the total enrollment to 3,901,997, it was announced last month by Louis H. Pink, president. Total enrollment for the first three months of 1948 was 154,772, Mr. Pink declared.

WANTED

Left-handed scissors and other surgical instruments



It was at a Chicago Convention Booth that a distinguished-looking, serious-appearing man spoke to a Weck executive.

"Do you folks make a LEFT-HANDED SCISSOR?"

The Weck executive said: "No, but come in and tell us what your problem is, sir."

The man—a prominent surgeon—did. He said he had asked that question for years, in all seriousness, as he is LEFT-HANDED. He had been told to turn the scissor over, or flippantly asked: "You wouldn't want a left-handed monkey wrench, would you?"

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At the Brooklyn plant of Weck a hand-made left-handed scissor now has been designed and is approaching completion.*

This true story is typical of the way Weck makes superior instruments for the skilled surgeons' trained hands to use.

If you have a "left-handed" or a "right-handed" problem the right place to write is to Weck.

*Since this advertisement was put in work the hand-made left-handed scissors have been completed and the surgeon referred to writes: "I cannot tell you how happy I am with the scissors . . . I don't believe any left-handed surgeon has any idea of how greatly his technical ability would be improved with left-handed scissors . . . they seem perfect . . . I am going to write my left-handed surgical friends about them."

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S.P.R. for Surgical Sutures

WASHINGTON, D.C. — A proposed simplified practice recommendation for surgical sutures has been submitted to manufacturers and a representative list of hospitals, surgeons and others for approval or comment, according to an announcement by the Commodity Standards Division of the National Bureau of Standards. Proposed by the purchasing, simplification and standardization committee of the American Hospital Association and developed in cooperation with a committee of the Surgical Suture Manufacturers Association and representatives of the American College of Surgeons, the recommendation includes a simplified list of recommended types and sizes of nonboilable surgical sutures, such as catgut, silk and nylon, for hospital use, the announcement said.

As proposed, this recommendation covers a standard designation number, size range, description and use, length and types of needles provided, for sutures used for general surgery, gastrointestinal, obstetrical and tonsil operations, it was explained.



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Modest in price . . . standard of quality for decades!

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● When you want a quality floor covering at *low initial cost*, you have every reason for preferring J-M Asphalt Tile. It is long-wearing, easy to maintain, and the units come in a wide range of attractive colors. Today asphalt tile is the most widely used and accepted floor covering for all types of commercial and institutional buildings!

BUT, when your preference is for the *best* there is, look to Terraflex! It is the revolutionary *new* flooring made of *plastic-asbestos*, pioneered and developed by Johns-Manville. Terraflex will outwear all other types of decorative flooring *two to one*. The resilient tile-like units are *unaffected* by greases, oils, alkaline moisture. They come in clearer, brighter colors . . . can be safely used on concrete floors in contact with the ground...withstand normal movement of wood sub-floors without breaking.

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This free Johns-Manville service helps you plan your maintenance budget, avoid unforeseen roofing expense



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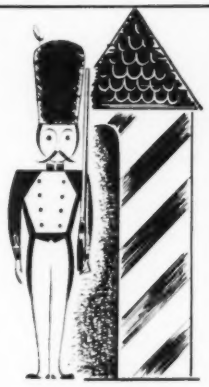
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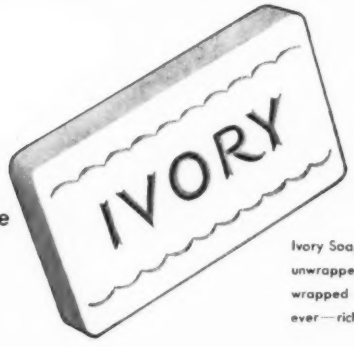
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NEWS...

Blue Cross-Blue Shield Plans Approve Program to Broaden Coverage

CHICAGO.—Meeting in their annual conference at Hollywood, Fla., last month, representatives of Blue Cross and Blue Shield plans approved a national action program to broaden Blue Cross coverage, facilitate the protection of members hospitalized out of their own areas, instigate an accelerated research program, and expand their public information program, the commission office here announced following the meeting.

The expanded enrollment program will concentrate upon enrollment of nongroup members, particularly in rural areas, and an extension of group enrollment through farm organizations, it was explained. Blue Cross care for the indigent was recommended for study. Activation of the Blue Cross Health Service, Inc., in the near future will answer the requests of national employers and unions for a uniform comprehensive contract, the commission announcement stated.

INTER-PLAN BANK

Among the provisions of the new program is the Inter-Plan Service Benefit Bank, which went into operation May 1, 1949. The bank was instituted to standardize the service received by Blue Cross members who are hospitalized outside their own plan areas.

Other projects suggested for plan development were the provision for broader benefits to meet the public demand for more comprehensive prepaid care; consultative service for plans; a choice of more than one contract to prospective groups, and the acceleration of such services as claims conversion, enrollment and transfer. A research program was recommended to collect and interpret Blue Cross data.

A program to establish public support of voluntary prepayment plans as opposed to compulsory health insurance was also approved, the commission reported. Information about the fundamentals of Blue Cross will be presented to those whose influence on Congressional action is significant, it was explained.

In the only change made on the Blue Cross commission, Guy W. Spring of Indianapolis replaced Richard O. Parker, Canton, Ohio.

From A to Z

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Surgical Scrub-up	Formula No. 99 Antiseptic Soap
Tile and terrazzo surfaces	Energetic Detergent
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Yes, from solarium to basement, there's a quality Armour Soap for your every cleaning job

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NEWS...

A.M.A. Announces New Requirements for Approval of Intern Training Programs

CHICAGO. — The American Medical Association last month announced approval of a residency specifically designed to train family doctors and new requirements for approval of hospitals for intern training. The residency for general practice will provide supervised training in the four major clinical divisions—internal medicine, surgery, obstetrics-gynecology, and pediatrics—as well as in the auxiliary services of anesthesiology, pathology and radiology, the Council on Medical Education and Hospitals explained.

The 870 hospitals which the council had previously accredited for general residency training will be expected to reorganize their programs in accordance with the new requirements for the general practice residency, an editorial in the *Journal of the American Medical Association* stated, emphasizing that the council's purpose is to encourage more young physicians to enter the field of general practice.

The council also reemphasized the importance of a well organized program for intern training, stating that internships arranged merely to provide hospitals with resident personnel to assist in the clinical work of the hospital cannot be approved. While the majority of internships approved are now of one year's duration, the council recommended longer periods of service.

For the first time, the council suggested a method for determining the number of interns to be appointed. The bed capacity of the hospital is used as a basis, with a range of 15 to 25 beds per intern recommended. Although the council does not establish a specific number of interns to be appointed by approved hospitals, the hospitals will no doubt comply with this suggestion in organizing their program, the *Journal* stated. Estimates indicate that 1380 hospitals can meet the present quantitative requirements set up by the council. The number now approved for intern training is 807. The council is making a survey of these hospitals for the purpose of assuring prospective interns of satisfactory training.

PERCENTAGE IS UNCHANGED

The percentage of internships vacant has remained essentially unchanged since last year, it is reported. The 807 approved hospitals offered 9124 internships as of May 1, 1949, 9118 internships in 1948. These hospitals reported that 19.7 per cent of the internships they offered were vacant in September 1948, and 20.5 per cent were vacant in May 1948.

"In considering the discrepancy between the number of internships offered and the number of physicians available for these positions, it should be remembered that the former figure measures the demand for interns by approved hospitals and not of necessity the actual need," the *Journal* pointed out. "These hospitals next year might well decide to offer 10,000 internships, or 8000, thereby increasing or decreasing the relative shortage. If all 1380 hospitals become approved, 16,000 interns would be required to staff them. Such a supply of interns is not presently available, nor is it likely to be in the near future. The majority of these hospitals, accordingly, will have to continue to render the same high type of patient care without relying on interns."

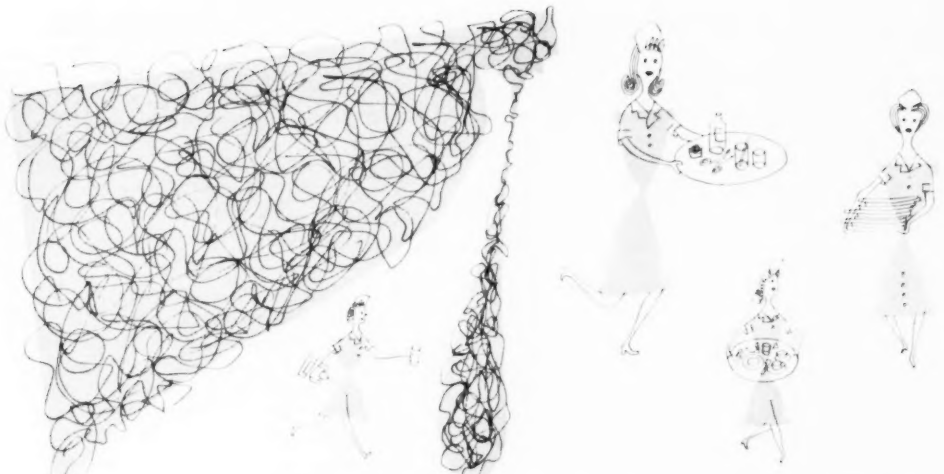
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NEWS . . .

Fire Marshal Warns of Hazards to Other Hospitals in Effingham Report

SPRINGFIELD, ILL.—A large number of hospitals and other institutions in Illinois are operating under the present fire prevention code with the same hazards that contributed to the disastrous fire at St. Anthony's Hospital in Effingham last April 5, State Fire Marshal Patrick Kelly warned in a report released here last month. Particularly noteworty, the report said, is the hazard attributable to increasing use of combustible materials in repair and modernization programs where owners and occupants are unaware of fire hazard or are misinformed concerning the combustibility of the materials used.

In his recommendations for a new state fire prevention code, contained in the report, the fire marshal included provision for the installation of fire detection alarms and protection devices in hospitals, periodic inspections by state fire safety officials where local ordinances are inadequate, establishment of a fire prevention division in the fire marshal's office to enforce the new code and appointment of a commission of competent fire safety officials to conduct studies and prepare suitable safety legislation.

Among the causes of the Effingham conflagration cited in the fire marshal's report were the age-dried woodwork and timbers in the 75 year old hospital building; unprotected vertical and lateral air spaces which served to increase fire drafts; presence of combustible fiber board as partitioning material and combustible fiber cover on hospital ceilings and walls; accumulation of repeated coats of paint and varnish on wall and woodwork surfaces, and lack of emergency fire fighting equipment in the hospital and inadequate public fire protection facilities.

The fire marshal described the work of volunteer fire fighters as heroic in the face of inadequate equipment. The actual cause of the fire was not determined.

"With this combination the fire, originating in the basement section of an unprotected laundry chute and having a considerable start before the arrival of the engineer, encountered no control other than the heroic efforts of the engineer and nuns using hand extinguishers," the report concluded. "It rapidly found its way up the unprotected laundry chute to the attic. Here, in readily combustible surroundings, it developed the flaming gases which blew back down the unprotected stairways to meet more fire coming up from the basement by way of unprotected stairways and develop the billows of burning gases which invaded the hospital rooms. The victims were probably asphyxiated by these gases before the fire took hold of the room structures.

"Simultaneously, the burning gases under expanding pressure invaded every concealed space in the age-dried structure. With the intense heat thus established, all combustible material on the upper floors burst into flame as its ignition point was reached. This is the only logical explanation of the very rapid fire involvement indicated by the statements of witnesses."

COMING MEETINGS

AMERICAN ASSOCIATION OF MEDICAL SOCIAL WORKERS, Municipal Auditorium, Cleveland, June 12-17.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Cleveland, Sept. 25-26.

AMERICAN CONGRESS OF PHYSICAL MEDICINE, Netherlands Plaza Hotel, Cincinnati, Sept. 6-10.

AMERICAN HOSPITAL ASSOCIATION, Cleveland, Sept. 26-29.

AMERICAN MEDICAL ASSOCIATION, Atlantic City, N.J., June 6-10.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Book-Cadillac Hotel, Detroit, Aug. 23-25. Institute, Aug. 26, 27.

AMERICAN PHYSICAL THERAPY ASSOCIATION, Copley Plaza Hotel, Boston, June 19-24.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Cleveland, Sept. 23-24.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Hotel Roanoke, Roanoke, Va., June 20-23.

AMERICAN SOCIETY OF X-RAY TECHNICIANS, San Francisco, June 5-10.

ASSOCIATION OF CALIFORNIA HOSPITALS, Recreation Center, Santa Barbara, Nov. 17, 18.

CATHOLIC HOSPITAL ASSOCIATION, St. Louis, June 13-16.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, duPont Hotel, Wilmington, Del., Nov. 14-15.

NATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, Somerset Hotel, Boston, June 10, 11.

NATIONAL SAFETY CONGRESS AND EXPOSITION, Oct. 24-28, Chicago.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS, Commodore Hotel, New York City, Nov. 7-9.

1950

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, April 12-14.

OHIO HOSPITAL ASSOCIATION, Neil House, Columbus, March 22-24.

SOUTHEASTERN HOSPITAL CONFERENCE, April 5-7.

TEXAS HOSPITAL ASSOCIATION, Buccaneer Hotel, Galveston, March 7-9.

Canned Foods as a Source of Vitamin A

Number 2 in a series of articles which summarize the conclusions about canned foods reached by authorities in nutrition research

Vitamin A is important in the nutrition of human beings of all ages. It is essential for growth, promotes accurate vision, and aids in the maintenance of the integrity and resistance of mucous membranes. (1)

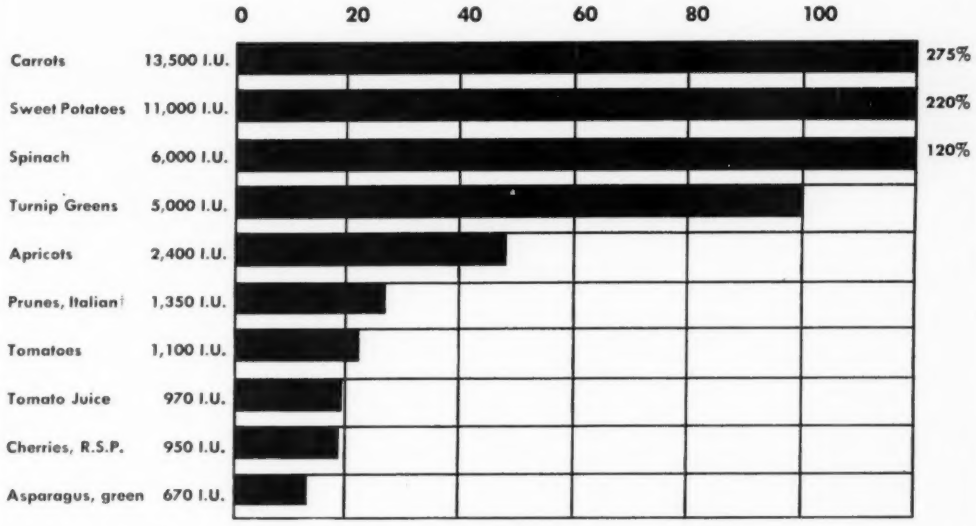
The animal body is dependent on the food ingested for its source of vitamin A since animal tissues cannot synthesize this vitamin. (2) Certain caretenoid pigments occurring in plants are precursors of vitamin A and are known as provitamin A. These are converted to vitamin A in the animal body.

Green and yellow vegetables such as carrots, sweet potatoes, and spinach are excellent sources of the provitamins of Vitamin A. (3) Dairy Products, eggs, and liver (including fish-liver oil) are important animal sources and supply largely vitamin A, although some of the provitamins may be present.

Vitamin A and provitamin A are both stable at high temperature in the absence of oxygen. The entire daily allowance of vitamin A may be obtained from a single serving of certain canned yellow or green leafy vegetables. (4)

Percentage of Recommended Daily Allowance* in 4-oz. (113 grams) Serving (4)

(Based on analysis of the entire can contents)



*(†Pitted weights. *Percentage based on Recommended Daily Allowance for moderately active male—5000 I.U.—National Research Council.*

(1) 1943. The Science of Nutrition. H. C. Sherman. Page 71. Columbia University Press, New York.

(2) 1939. The Newer Knowledge of Nutrition. McCollum, Orent-Keiles, Day. Page 300. MacMillan, New York.

(3) 1945. Chemistry and Physiology of the Vitamins. H. R. Rosenberg. Page 39. Interscience, New York.

(4) 1947. The Canned Food Reference Manual, American Can Company. Pages 242-3. Rogers-Kellogg-Stillson, New York.

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The Seal of Acceptance denotes that this advertisement has been reviewed by the Council on Foods and Nutrition of the American Medical Association and has been accepted by them.

NEWS...

Admissions to Hospitals Reach High of 16,422,744, A.M.A. Journal Reports

CHICAGO.—A patient was admitted to a hospital in the continental United States every 1.9 seconds during 1948 and a live baby was born in a hospital every 11 seconds, according to the 28th annual report of the Council on Medical Education and Hospitals of the American Medical Association, published here last month. Dr. F. H. Arestad, associate secretary of the council, and Mary A. McGovern presented the report in the *Journal of the American Medical Association*. Their figures reveal that in comparison with 1947 the number of hospital beds has decreased from 1,425,222 to 1,423,520 and the number of admissions has increased from 15,829,514 to 16,422,774, a new high in the utilization of hospital service. The previous record was 16,257,402 admissions in 1945.

The apparent discrepancy between increased admissions and decreased number of beds is clarified when the average length of stay per patient in general hospitals is considered, the writers explained. In 1947 the average patient remained 11.4 days in a general hospital; in 1948 he was discharged after 10.5 days, a gain to the patient of about one day. The number of patient days has decreased from 444,288,585 to 444,261,210.

Represented in the report are 6335 hospitals registered by the American Medical Association, including 1387 approved for internships and/or residencies in specialties and 2611 accredited by the American College of Surgeons as meeting unconditionally its minimum requirements for general standardization. The number of hospitals is 59 more than were reported in 1947.

The decrease in total bed capacity is accounted for entirely in the government group of hospitals, federal hospitals alone reporting 28,106 fewer beds than last year, it is explained. With admissions to government hospitals increasing by 86,147, admissions to civilian hospitals increased by more than 500,000. Births in 1948 totaled 2,794,281, compared with the all time record of 2,837,139 in 1947.

OCCUPANCY DECREASES

The occupancy rate for the general hospital group, to which 92 per cent of all patients were admitted, decreased from 77.1 per cent in 1947 to 75.9 per cent in 1948. The percentage of beds occupied in government hospitals shows an increase in 1948 for all groups except the hospitals operating under city control. The percentage of beds occupied in nervous and mental hospitals increased from 95.7 in 1947 to 96.1 in 1948, and nervous and mental diseases still account for more than half of the patients occupying hospital beds. Of the average census of 1,217,154 patients, 54.6 per cent were in hospitals of this type.

The survey shows an appreciable increase in nursing personnel in hospitals as compared with 1947; gains occurred in all professional and auxiliary nursing groups. The number of graduate nurses exclusive of private duty nurses employed in hospitals increased from 167,354 in 1947 to 196,120, the full-time general duty nurses, from 86,218 to 104,041, and the practical nurses and attendants, from 119,746 to 141,834. The state accredited schools of nursing reported a student enrollment of 100,174, as compared with 94,133 in 1947, the report stated.



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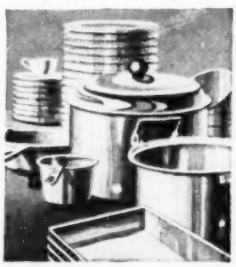
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NEWS...

University of Illinois Offers Program Leading to Degree in Nursing

CHICAGO.—A new program leading to a bachelor of science degree in nursing will be inaugurated this fall by the University of Illinois and three Chicago hospitals, it was announced here last month. St. Luke's, Cook County and Presbyterian Hospital schools of nursing already have been approved for the affiliation program, and other hospital schools which qualify are expected to apply for inclusion, a university announcement said.

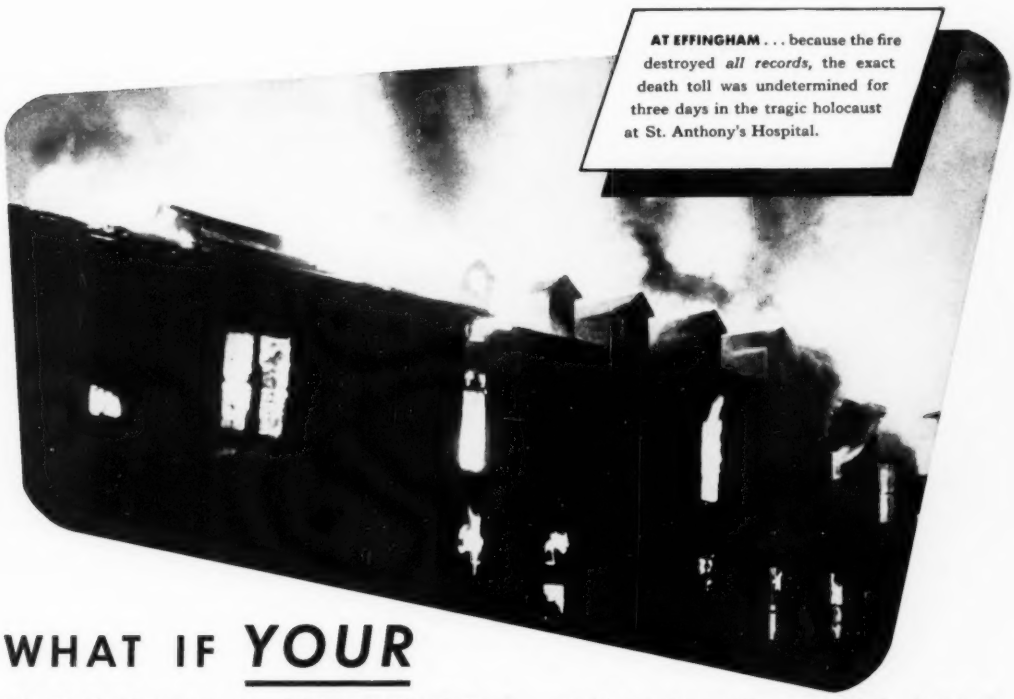
"This program has been set up to meet the present demand by many young women for a more attractive educational program in qualifying for a career in nursing," Dr. Andrew C. Ivy, vice president of the university in charge of the Chicago professional colleges, said. "With its inauguration, the university is extending its educational facilities for the purpose of rendering even greater service to the people of the state."

The three nursing schools in the affiliation program have combined facilities for 1075 nursing students at the present time, it was explained. The program will be under the supervision of a director of nursing education and a coordinator who will be appointed by the University of Illinois. An administrative coordinating committee composed of representatives of the university and the affiliated schools will function in an advisory capacity.

Affiliates With Loyola U.

CHICAGO.—Affiliation of Loretto Hospital with the Stritch School of Medicine of Loyola University here was announced last month by Sister Mary Stephanie, hospital administrator, and the Very Rev. James T. Hussey, S.J., president of Loyola. The affiliation with Loretto is the second important step in the formation of the new Loyola University hospital group, it was reported in the announcement.

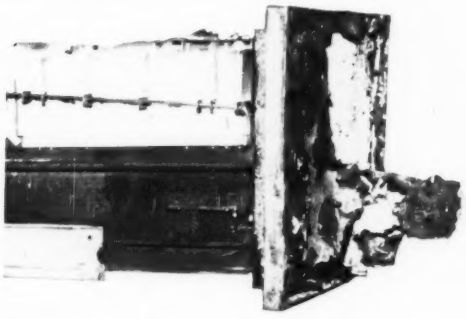
Last fall, the University Hospital was made available to the school as a teaching and research unit. Under the terms of the agreement, the educational program at Loretto for the training of young physicians will be greatly broadened and house physicians will have the opportunity of rotation between Loretto and the University Hospital, it was explained.



AT EFFINGHAM . . . because the fire destroyed *all records*, the exact death toll was undetermined for three days in the tragic holocaust at St. Anthony's Hospital.

WHAT IF *YOUR* HOSPITAL RECORDS BURNED TODAY?

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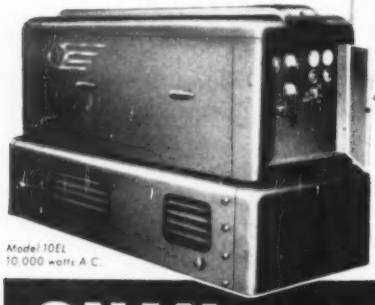
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NEWS...

Hospitals Are on Trial, National Hospital Day Speaker Tells Audience

NEW YORK.—Voluntary hospitals are on trial to prove that they can run the nation's hospital system better than the government could, Dr. Eli Ginzberg of Columbia University said at a National Hospital Day meeting of the Greater New York Hospital Association. The occasion was celebrated by special ceremonies in many hospitals here and throughout the country.

Dr. Ginzberg called on hospitals in New York to make educational and treatment facilities available to every qualified physician in the city instead of only the 50 per cent having staff appointments. He praised the Hospital Council of Greater New York for its leadership in working toward a unified hospital plan for the entire metropolitan area.

In a National Hospital Day message addressed to President Joseph G. Norby of the American Hospital Association, President Truman paid tribute to "the men and women whose spirit of service to humanity has made possible the building and operation of hospitals throughout the country." The federal government has recognized the central place of the hospital in the provision of adequate health services to the nation, President Truman stated. The country owes a special debt of gratitude, he said, "to the men and women who administer and serve in our hospitals, often at great personal sacrifice, often without weighing the burdens they carry or the hours they serve."

New York Group Elects

NEW YORK.—Very Rev. Msgr. John J. Curry, director of health and hospitals, Catholic Charities, New York, was elected president of the Greater New York Hospital Association, representing 97 voluntary nonprofit hospitals and 22 municipal hospitals in the Greater New York area, April 29 at the annual meeting of the association. Other officers elected were: president-elect, James Russell Clark, director, Brooklyn Hospital; vice president, Fred Heffinger, superintendent, Manhattan Eye, Ear and Throat Hospital; treasurer, Louis Miller, superintendent, Jewish Memorial Hospital; secretary, Wilson Keller, director, Hospital for Special Surgery.

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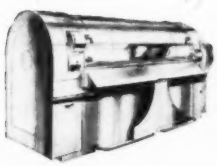
In laundries, Monel is known for its tough strength and for its ability to last in heavily worked, heavily loaded laundry wheels for 20, 25 or 30 years. Monel is known, too, for its freedom from rust and freedom from pitting.

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NEWS...

Mary M. Roberts Retires as Editor of Nursing Journal

NEW YORK.—Mary M. Roberts, for many years editor of the *American Journal of Nursing* and one of the nation's foremost nurse leaders, has retired after 28 years' service with that publication, the *Journal* announced last month. She will be succeeded by Nell V. Beeby, who has been a member of the *Journal* staff.

Under Miss Roberts' regime the *American Journal of Nursing* circulation increased from 20,000 to 100,000, the *Journal* said. "The record of Miss Roberts' interests and activities extends far beyond the demands which have been made on her by her position as editor," a *Journal* announcement stated. "She not only has served on countless nursing committees and commissions but also has been a valued member of innumerable medical, hospital and public health study groups, both national and international. During part of Miss Roberts' tenure as editor of the *Journal* she also organized and directed the Nursing Information Bureau for the American Nurses' Association, which was operated in cooperation with the National League of Nursing Education and National Organization for Public Health Nursing."

Until her retirement, Miss Roberts was a representative on the Joint Commission for the Improvement of the Care of the Patient, sponsored jointly by the American Nurses' Association, the American Hospital Association, American Medical Association and National League of Nursing Education.

At the National League of Nursing Education meeting held in Cleveland last month, Miss Roberts was presented with the Mary Adelaide Nutting award, given for outstanding contributions to the advancement of nursing.

Army Adds Valley Forge to Hospital Training Program

WASHINGTON, D.C.—Valley Forge Army General Hospital, Phoenixville, Pa., will participate in the graduate professional education program beginning July 1, it was announced recently by Maj. Gen. R. W. Bliss, army surgeon general. This will bring the number of general hospitals participating in this program to nine and will open a new source of training to young physicians interested in the Army Military Intern Program. The army has extended an invitation to medical students to visit its training hospitals during the summer months. Valley Forge, located within 25 miles of Philadelphia, will make it possible for students in this area to inspect army medical teaching facilities.

The military intern program offers graduate professional training opportunities to selected graduates of medical schools approved by the American Medical Association. Successful candidates are assigned to army general hospitals which are approved for such teaching by the A.M.A. Council on Medical Education and Hospitals.

Three hundred internships are available yearly. Appointments begin on July 1 of each year and terminate June 30 the following year. After receipt of their commissions as reserve first lieutenants, successful appointees are called to active duty with full pay and allowances. They are offered the opportunity to apply for regular army medical corps commissions at the end of their internships.



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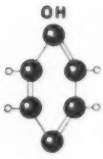
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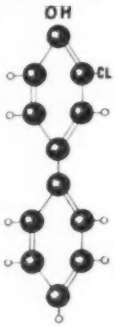
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NEWS...

Ginzberg Issues Interim Report on Financial Structure of Hospitals

NEW YORK.—The financial position of voluntary hospitals "is not so precarious as to warrant immediate governmental assistance," according to the interim report recently made available by Dr. Eli Ginzberg of Columbia University, director of the hospital study for the State of New York. Dr. Ginzberg's group is studying the financial structure of the voluntary hospital system; the state hospital system in New York; the changing rôle of the hospital, particularly in relation to medical practice, and the administrative and financial relationship between voluntary and government agencies interested in hospital care.

The conclusion that voluntary hospitals do not need immediate assistance is based on the interim finding that "in general, hospital deficits have not been increasing and that the average deficit is not very large," the report said. There was no marked change in the debt position of hospitals during 1948, it was indicated, and while costs in general may continue to rise "no radical increase in hospital costs need be anticipated in the immediate future."

In presenting the interim report, Dr. Ginzberg emphasized that many groups had reported financial conditions contrary to the majority finding and that even regions reporting favorably for the moment indicated "great concern about the basic weakness of the financial structure of hospitals."

Dr. Ginzberg said the study would be continued, looking toward release of a final report next September.

Dedicates New Cyclotron

ROCHESTER, N.Y.—The second largest cyclotron in the world was dedicated late in March at the University of Rochester. Dr. Lee A. DuBridge, president of the California Institute of Technology, in speaking at the dedication, mentioned new nuclear power plants, a possible cure for cancer, or a trip to the moon as within the realm of possibility for the great instrument. What it will actually accomplish is to yield to skilled scientists new knowledge about the behavior, structure and characteristics of nuclei, Dr. DuBridge declared.



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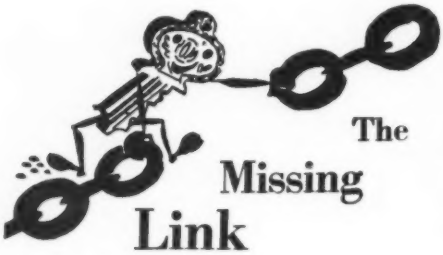
NEWS...

Columbia Announces Residency Appointments for Hospital Students

NEW YORK.—Columbia University's School of Public Health has announced the following administrative residency appointments of students in its graduate course in hospital administration:

Harold P. Alden, St. Francis Hospital, San Francisco; Herbert E. Appleyard, M.D., University of Cleveland Clinics, Cleveland; Mario Fahsen, M.D., Lebanon Hospital, New York City; Humberto Garces, M.D., return to Quito, Ecuador; Romeo Gibbs, Freedmen's Hospital, Washington, D.C.; Virgil M. Lumsden, Johns Hopkins Hospital, Baltimore; Cornelius P. Lynch, New Rochelle Hospital, New Rochelle, N.Y.; John F. Miller, Jewish Hospital of Brooklyn, Brooklyn, N.Y.

Alexander McAliley, Lowell General Hospital, Lowell, Mass.; James McGuire, Roosevelt Hospital, New York City; Ralph L. Perkins, U.S. Marine Hospital, Staten Island, N.Y.; Samuel Polanco, Veterans Administration Center, San Juan, P.R.; Joseph Potorski, Ellis Hospital, Schenectady, N.Y.; Donald A. Rece, Medical College of Virginia Hospital Division, Richmond; James A. Rourke, Harper Hospital, Detroit; Frank W. Scott, Freedmen's Hospital, Washington, D.C.; Malcolm Smith, Montefiore Hospital, New York City; Raleigh Smith, Hartford Hospital, Hartford, Conn.; Tracy Storch, New York Hospital, New York City; Raul Vera, M.D., Grace Hospital, Detroit; Gerald Wagner, Mary Hitchcock Memorial Hospital, Hanover, N.H.; Joseph Williamson, Presbyterian Hospital, New York City; Marion J. Wright, Stanford University Hospital, San Francisco.



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Nassau Hospital Opens Hematological Laboratory

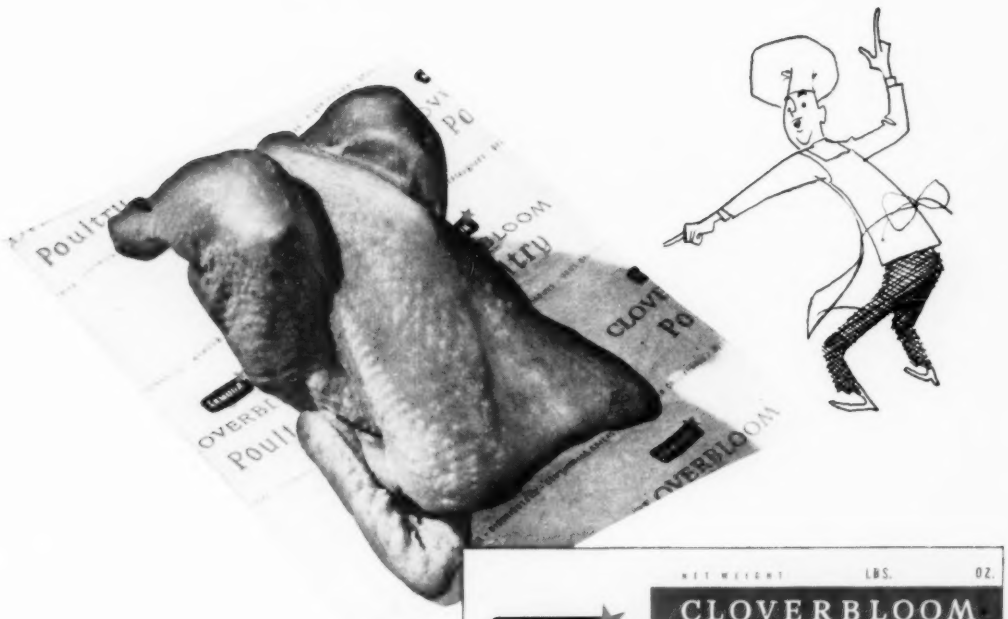
MINEOLA, N.Y. — A new hematological research laboratory consisting of a suite of four rooms on the top floor of the private pavilion has been opened at Nassau Hospital here. These have been completely remodeled and equipped with special apparatus required for the work in progress. One of the rooms will be used entirely for serological work, including Rh testing.

Director of the new laboratory is Dr. Eric Ponder who has been in charge of research work at Nassau Hospital since 1940. This new laboratory, hospital officials stated, is another step in the development of a program which began at Nassau Hospital in 1941 when funds were set aside for the study of blood and blood diseases.

Standard for Tufted Spreads

WASHINGTON, D.C.—A recommended commercial standard for tufted bedspreads has been submitted to producers, distributors and users for acceptance, according to an announcement of the commodity standards division, National Bureau of Standards. Proposed by the Tufted Textile Manufacturers Association, the recommended commercial standard includes two sizes (twin and double), with plus and minus tolerances, methods of test, and means for identification of the material conforming to the recommended standard. It is the purpose of industry to expand this standard later by the addition of quality requirements for the backing and tufting yarn, color-fastness and other elements of quality, it was explained.

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H-1	Packed	19 to 20#	1# 2 oz. to 1# 3 oz.
H-02	6 Birds	21 to 22#	1# 4 oz. to 1# 5 oz.
H-2	(12 Halves)	23 to 25#	1# 6 oz. to 1# 7 oz.
H-03	Per Box	26 to 27#	1# 8 oz. to 1# 9 oz.
H-3		28 to 30#	1# 10 oz. to 1# 12 oz.
	FRYERS		
H-04	Whole	31 to 32#	1# 13 oz. to 1# 15 oz.
H-4	Birds	33 to 35#	2# to 2# 2 oz.
H-05	(6 Birds)	36 to 38#	2# 3 oz. to 2# 5 oz.
H-5	Per Box	39 to 42#	2# 6 oz. to 2# 9 oz.
H-06		43 to 47#	2# 10 oz. to 2# 15 oz.

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NEWS...

Expand Membership of Committee for Health

WASHINGTON, D.C.—Expansion of the membership of the Committee for the Nation's Health was announced April 11 by Dr. Channing Frothingham, chairman of the committee. New members include Gov. Chester Bowles of Connecticut, Gen. William J. Donovan, Wayne Chatfield-Taylor, John Gunther, Walter Wanger and others.

Dr. Frothingham stated that the increased membership on the committee was evidence of the expanding interest in and support for national health insurance legislation. He noted that the new members include representatives of both political parties, doctors, lawyers, political figures and laymen.

Governor Bowles and Walter Wanger joined the committee as honorary vice chairmen. General Donovan, Mr. Chatfield-Taylor and Mr. Gunther are new members of the committee's board of directors. Other new members of this group include: Dr. Paul B. Cornely, medical director of Freedmen's Hospital, Washington, D.C.; Dr. Harry Goldblatt, Institute of Medical Research, Cedars of Lebanon Hospital, Los Angeles; Newbold Morris, New York City attorney; Eric Peterson, secretary-treasurer of the International Association of Machinists; Franklin D. Roosevelt Jr. of New York City, and Robert F. Wagner Jr., also of New York City.

Pharmacy Institute to Be Held in Berkeley

CHICAGO.—An institute on hospital pharmacy will be conducted on the University of California campus in Berkeley, Calif., from June 27 to July 1, under the sponsorship of the American Hospital Association, the American Pharmaceutical Association and the American Society of Hospital Pharmacists, according to an announcement released here last month.

The purpose of the institute will be to help the hospital pharmacist meet his responsibility in the management of his department, it was explained.

The sessions will take up technical, administrative and related subjects; pharmacists will not only learn of advancements in preparation of drugs, but also receive instruction on legal aspects of pharmacy and interprofessional relationships with other hospital staff members, the announcement said. In addition, several group discussions and a field trip to a Berkeley pharmaceutical laboratory are on the institute schedule.

To Train Male Nurses

NEW ORLEANS.—The Hotel Dieu School of Nursing here will accept male students for the regular three-year course, beginning with the August class, Sister Aloysius, director of the school of nursing and nursing service, announced last month. The action is being taken to meet the pressing need for more registered male nurses, the announcement said.

Men students will follow the same curriculum as women with the exception of classes in obstetrics and gynecology, it was explained. Present plans call for the men to be housed in the hospital. Male student nurses will be assigned to duty on the hospital halls devoted to the care of men patients. No limit has been set upon the number of applicants which the school will accept, Sister Aloysius stated.





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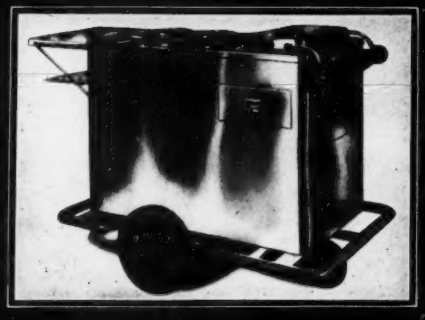
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NEWS...

Speakers Debate Health Insurance at Forum of School for Social Research

NEW YORK.—A forum on compulsory national health insurance held at the New School for Social Research recently brought two speakers approving the idea, two opposing it, and one holding middle ground.

Dr. Ernest P. Boas of Mount Sinai Hospital declared that many persons cannot afford the tremendously increased cost of medical care and that "only national compulsory health insurance can abolish financial handicaps which prevent so large a proportion of the population from receiving adequate medical care."

H. David Davis of the British Information Services reported that at the end of last year 95 per cent of the British people and about 90 per cent of the doctors were cooperating.

"The effect in psychological terms may never be fully assessed," Mr. Davis declared. "The nagging fear of sickness has now been removed, and the whole pattern of human interrelationships, particularly within the family, is likely to be radically altered with enormous individual and social advantages."

Edward T. Welch, secretary of the Society for Medical Jurisprudence, maintained that compulsory health insurance would result in a poor standard of medical care. Dr. George T. Peck, attending surgeon at Memorial Hospital, upheld the same point of view.

Dr. Dean A. Clark, medical director of the Health Insurance Plan of Greater New York, refused to speak either for or against national health insurance but stated that the important thing is "to make sure that good medical service is furnished on a prepayment basis regardless of whether such prepayment is voluntary or compulsory."

Dublin Urges Recruitment of More Trained Personnel

NEW YORK.—The lack of adequately trained professional and technical health personnel in sufficient numbers to meet the need is the weakest link in the chain of health services today, Thomas D. Dublin, M.D., executive director of the National Health Council, told members in his report before the 29th annual meeting last month at the Hotel Roosevelt. He recommended increased efforts at recruitment, training and placement of qualified workers.

Dr. Dublin also reported progress in efforts to promote full-time health departments throughout the country and cited the council's success in its efforts to enlist greater citizen participation in public health matters through community health planning councils.

Philip R. Mather of Boston was elected president of the council for the fourth consecutive year. Others reelected were: vice president, Ernest L. Stebbins, M.D., Baltimore; treasurer, Haven Emerson, M.D., and assistant treasurer, Franklin M. Foote, M.D. James E. Perkins, M.D., was elected secretary.

Four additional organizations were elected to membership in the council which consists of leading national health agencies, voluntary and governmental. The newly elected agencies are: The American Medical Association and the National Infantile Paralysis Foundation, both elected to active membership; the American Physical Therapy Association and the National Multiple Sclerosis Society, associate members.



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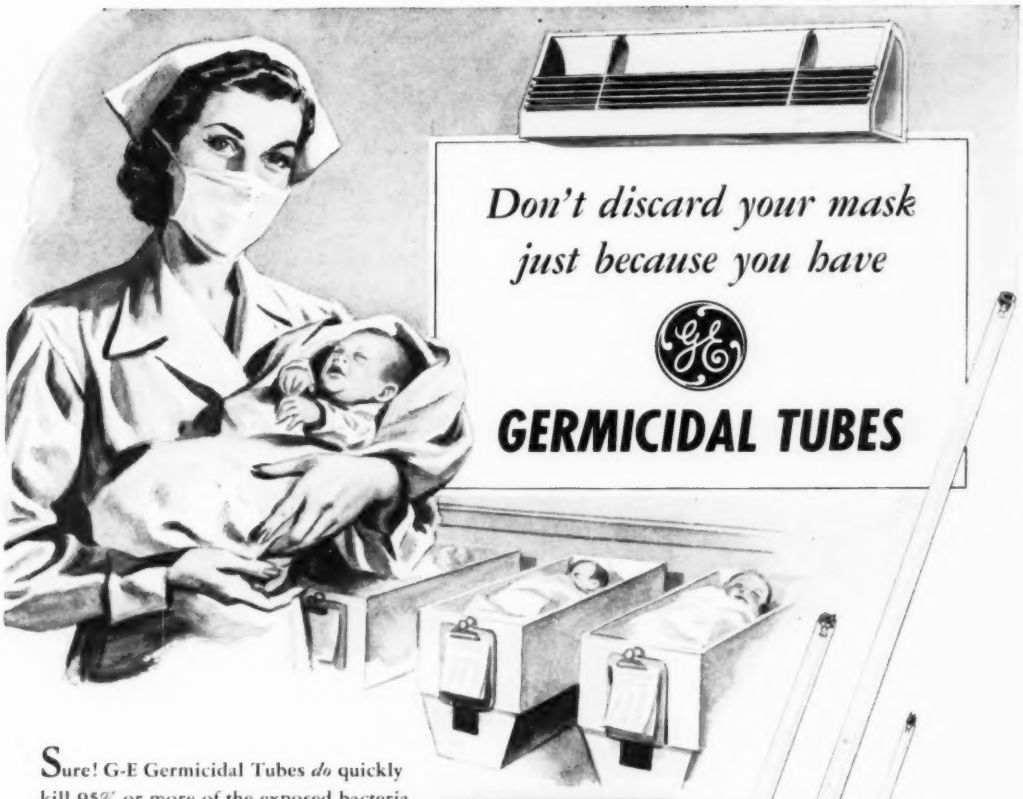
Fairchild's optional high-speed film drive produces 17 exposures every 24 seconds to provide a rapid sequence series of negatives for angiographic study of heart conditions.

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Don't discard your mask just because you have

GERMICIDAL TUBES

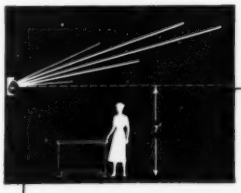
Sure! G-E Germicidal Tubes *do* quickly kill 95% or more of the exposed bacteria, viruses and mold in the air! They *are* good air disinfectors. They *are* a valuable supplement to routine hospital aseptic procedures . . . but they *are not* a substitute for them.

Many progressive hospitals, anxious to provide the maximum health protection for patients and staff are using the ultraviolet energy of G-E Germicidal Tubes to help prevent the spread of respiratory infections. And they retain usual sanitary procedures, too.

Experience has demonstrated that General Electric Germicidal Tubes do reduce the concentration of airborne germs in surgeries, wards and nurseries.

★

Write for the free booklet, "Air Sanitation" and a folder on hospital use of G-E Germicidal Tubes. Address General Electric Company, Department 166-MH6, Nela Park, Cleveland 12, Ohio.



WHAT THEY ARE— WHAT THEY DO

- ★ G-E Germicidal Tubes kill 95% or more of the germs in the air through which the energy passes.
- ★ G-E Germicidal Tubes must be used in properly designed and correctly installed fixtures to prevent irritation of human eyes and skin. Usually the tubes are placed to disinfect the area in a room above eye level.
- ★ The number of germs in the air is reduced as disinfected air from upper areas circulates down to breathing areas. However, ultraviolet energy cannot prevent respiratory infections being spread by close contact.
- ★ The Council on Physical Medicine of the American Medical Association has accepted G-E Germicidal Tubes for air disinfection in nurseries, wards and operating rooms in hospitals.

GENERAL ELECTRIC

ABOUT PEOPLE

(*Continued From Page 86.*)

Anthony C. Garrick has been appointed assistant administrator to **Elwin Glover** at Samaritan Hospital, Troy, N.Y. Mr. Garrick will receive his master's degree in hospital administration from Northwestern University this month.

Ralph W. Tarr, former assistant director of Michael Reese Hospital, Chicago, is now director of the Missouri-Delta Hospital, Sikeston, Mo.

Ann Styer has been appointed superintendent, and **William Simko,** registrar, of Doctors Hospital, Newark, N.J., it has been announced by **Dr. Irving E. Fink,** hospital director. Miss Styer was formerly superintendent of hospitals in Du Bois, Pa., and Sacramento, Calif., and was assistant superintendent at the Hospital and Home for Crippled Children, Newark, N.J., for 12 years. Mr. Simko is a graduate of the University of Georgia; he served with the 98th Evacuation Hospital in an administrative capacity during the war.

Lilyan Zindell has resigned as administrator of Vail Hospital, Topeka, Kan., a position she has held since October 1947. Previously, Miss Zindell was administrator of Atlantic Memorial Hospital, Atlantic, Iowa.

Walter R. Hoefflin Jr. has been appointed administrator of the Methodist Hospital of Southern California, Pasadena. He formerly was head of the Pasadena Sanitarium, a neuropsychiatric institution.

Department Heads

Dr. Richard H. Young, dean of the college of medicine at the University of Utah, has been appointed dean of Northwestern University Medical School. He will succeed **Dr. J. Roscoe Miller,** who becomes president in July upon the retirement of **Dr. Franklyn B. Snyder.**

Dr. George P. Berry, associate dean of the school of medicine and dentistry at the University of Rochester, has been appointed dean of the Harvard Medical School. Dr. Berry succeeds **Dr. C. Sidney Burwell,** who resigned to devote his full time to teaching and research.

Donald C. Edmonds has resigned as personnel director of the George Washington University Hospital, Washington, D.C., and will make his future home in New York City.

Mrs. Elsie V. Marra, director of nurses at Hamot Hospital, Erie, Pa., has retired.

Frances E. McClelland has been named assistant director of nursing at Presbyterian Hospital School of Nursing, Pittsburgh. A graduate of the Pennsylvania Hospital School of Nursing, Miss McClelland's experience includes both teaching and administration, with duty in both the army and navy nurse corps.

Miscellaneous

Thomas J. Watson Jr., vice president of International Business Machines Corporation, has been appointed chairman of the 1949 campaign of the United Hospital Fund, New York City.

Minnie E. Pohe has been appointed assistant chief of the Education and Training Division, Veterans Administration, in charge of the graduate nurse education program. **Mrs. Ruth Boyer Scott, R.N.,** has been appointed to the Professional Standards Division.

Dr. George C. Erickson, Dr. Dorothy Bartels, and **Dr. Jose Gonzales** have been added to the staff of the American College of Surgeons as assistants in the hospital department. **Dr. Harold R. Hennessy** has been added to the staff of the

The Nurse that never Sleeps



Magnetic Type Calling Station

Day or night, there's no let-up in the "special nurse" care of a Couch Signaling System. There's constant security for *every patient* . . . greater freedom for regular nurses, added efficiency.

The magnetic type call station pictured was formerly made by Chicago Signal Co. It is preferred equipment in many hospitals because of the slight pressure required to operate it. The standard locking button and pull cord stations are also regular items in the Couch Line of hospital equipment.

The Nurse's Call is only part of the versatile Couch electric "nerve system" for hospitals. For full information on Doctors' Paging . . . Doctors' In and Out . . . Fire Alarm . . . Private Telephone . . . Return Call Systems, send for Bulletin H-1.

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Photograph of surgeon's scrub-up room, St. Mary's Hospital, Rochester, Minn.

Duraclay *

at St. Mary's Hospital

To look at these scrub-up sinks of Duraclay you would think they were installed yesterday—but, as a matter of fact, they have been rendering service twenty-four hours a day ever since St. Mary's Hospital was built.

Duraclay was specifically developed by Crane ceramists for hospital service. Here are the reasons why you will find fixtures of Duraclay in such a large percentage of the nation's leading institutions:

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"We have found that the Duraclay sinks that we have installed here at St. Mary's Hospital have answered our needs very well and have taken care of the service required of them. They have withstood the treatment given this type of material in hospital installations."

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department of clinical research to assist in the program of approval of cancer clinics and cancer detection centers.

Dr. Henry B. Makover has been appointed director of survey by the Health Insurance Plan of Greater New York. He will be responsible for conducting a study and critique of the medical services provided by the group practice units associated with the plan.

Deaths

Dr. Fred R. Driesbach, president of Dansville Memorial Hospital, Dansville, N.Y., from 1927 to 1946, died April 25. Dr. Driesbach retired in 1947 after 58 years of service as a physician.

Hospital Pharmacists Establish Division at A.Ph.A. Headquarters

WASHINGTON, D.C.—The American Society of Hospital Pharmacists has established a division of hospital pharmacy at the national headquarters of the American Pharmaceutical Association here. The policy committee of the hospital pharmacy division includes in its membership a representative of the American Hospital Association and of the Catholic Hospital Association. Worth Howard, superintendent of City Hospital of Akron, Ohio, represents the A.H.A. and Sister Adelaide, superintendent of St. Joseph's Hospital in Lorain, Ohio, the Catholic Hospital Association.

One of the principal projects of the division is the adoption and promulgation of minimum standards for hospital pharmacy. A committee of the American Society of Hospital Pharmacists has been at work on these standards for a number of years and the policy committee has now approved and made them available to the membership for suggestions.

It is anticipated that these standards will be submitted to the American College of Surgeons, the American Medical Association, the American Hospital Association and the Catholic Hospital Association for approval in the near future.

Sample surveys of hospital pharmacies will then be made to determine the practicality of the standards, after which it is expected that hospital pharmacies may be rated in accordance with the standards adopted.

Deny DDT Is Cause of "Virus X" Disease

WASHINGTON, D.C.—Statements that DDT is responsible for causing the so-called "virus X" disease of man and "X" disease of cattle are totally without foundation, officials of the Federal Security Agency and the U.S. Department of Agriculture stated after a meeting of the principal government agencies concerned with the utilization of DDT in national and international health and economy.

"It is well recognized that DDT, like other insecticides, is a poison," government officials stated. "This fact has been given full consideration in making recommendations for its use. There is no evidence that the use of DDT in accordance with the recommendations of the various federal agencies has ever caused human sickness due to the DDT itself. This is despite the fact that thousands of tons have been used annually for the past four or five years in the home and for crop and animal protection. However, minor toxic symptoms may be produced by kerosene and various solvents used in DDT and practically all other insecticidal mixtures.

"There is no justification for public alarm as to the safety of the milk supply from the standpoint of DDT contamination."

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Airkem counteracts those familiar "institutional" odors caused by vitiated air plus the smell of antiseptics and cleaning compounds. It also counteracts the nine chronic hospital odors listed below, which have such a detrimental effect on the well-being of your patients and on the morale and efficiency of your entire staff. Airkem also builds good will with visitors.

By means of wick bottles, wall cabinets and mechanical dispensing units, Airkem offers an effective and inexpensive means of overcoming one of the most difficult problems encountered by hospital management. Airkem is widely used in hundreds of hospitals from coast to coast, including some of the world's largest medical centers.

Your patients, your doctors, your nurses and maintenance crew will all benefit from the odor-free atmosphere which Airkem provides. In addition, Airkem will improve your relations with the visiting public.

Order Airkem from your local Airkem representative or write Airkem, Inc., 241 East 44th Street, New York 17, N. Y.

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Counteracts Odors Originating in:

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9 Kitchens

"We found this new McCray Koldflo reduced our operating costs in our short order department 32%"

—says Mr. John Morton of Lincolnwood, Illinois



McCray's new 40 cu. ft. Reach-In for Commercial Kitchens

"IN THIS DAY of high operating costs, high food costs, and customer resistance to high prices, a restaurant operator has to streamline his whole operation to maintain profits.

"As one step in eliminating wasted time, we decided to install a reach-in refrigerator in our short order department. Of course, we selected the McCray SA40, because in all my experience, I have found that McCray products do an effective job of food preservation and dove-tail into an efficient operating procedure better than any other make of refrigerator.

"After a three month trial during a very busy season, we found the new McCray Koldflo reach-in reduced our operating costs in our short order department 32%. This piece of equipment will have paid for itself within a year, and we have already ordered another one to promote more profits for us."



Smart new landmark just outside of Chicago, the House of Pierre carries its streamlining right to the spacious kitchens where a McCray Koldflo is an important factor in good kitchen organization.



John D. Morton

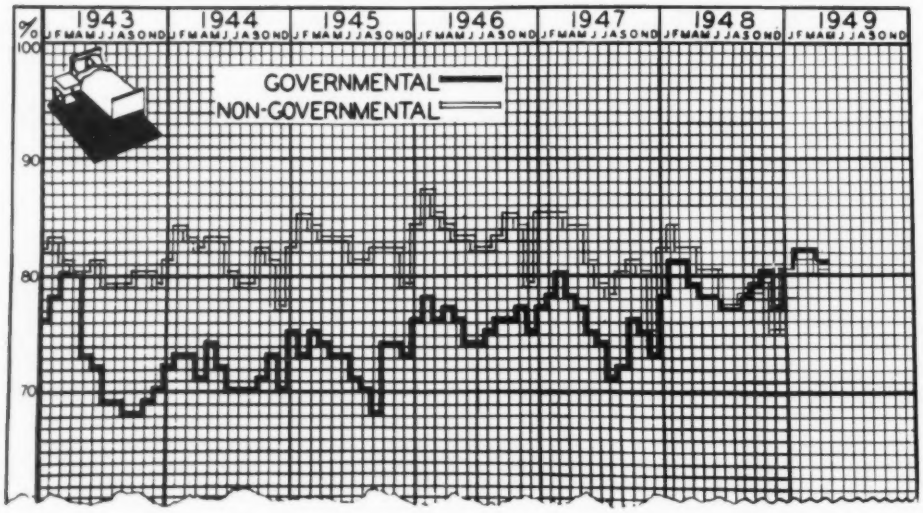
THE HOUSE OF PIERRE
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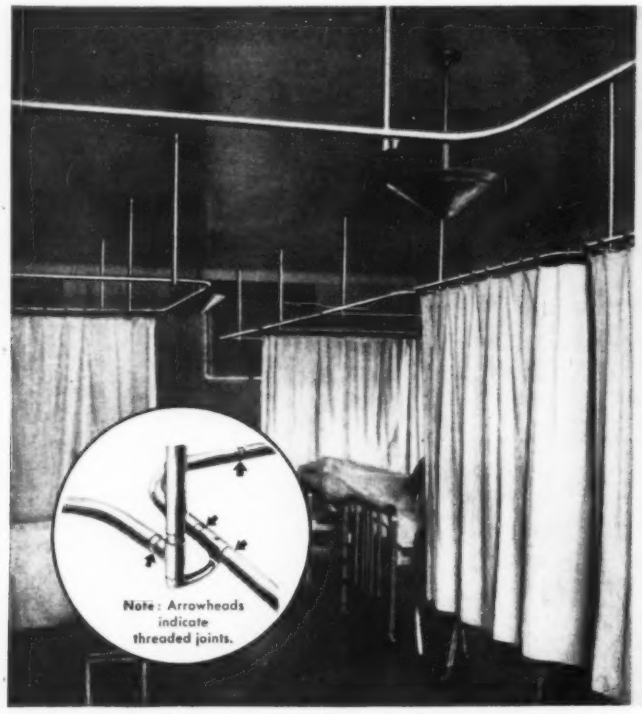
WRITE 966 McCRAY COURT, KENDALLVILLE, IND. DISTRIBUTORS IN PRINCIPAL CITIES—SEE TELEPHONE DIRECTORY

New Construction Below Last Year's Total



Occupancy of nongovernmental hospitals reporting to the Occupancy Chart continued in April at levels well below those which have prevailed during the same season in recent years. At 80.4 per cent of capacity, the average occupancy for 1949 compared to 82 last year, 83 in 1947 and 84.2 in 1946. Occupancy of governmental hospitals, on the other hand, was 80.8 per cent, compared to 79.1 in 1948 and 77.7 in 1947.

New construction reported for May totaled $80,633,520, approximately 10 per cent below the total reported for the same period last year. The $245 million reported for the year to date is $75 million under last year's total for the same cumulative period.



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Here is the cubicle that is rapidly gaining favor with leading hospitals throughout the country...the ARNCO Aluminum CUBICLE...the result of Nelson "know-how" engineering in cubicle design. Strong, light in weight, easier to install, less ceiling stress, and greater economy in shipping because of less weight per unit. Also available in chrome plated brass when specified. Write for full details.

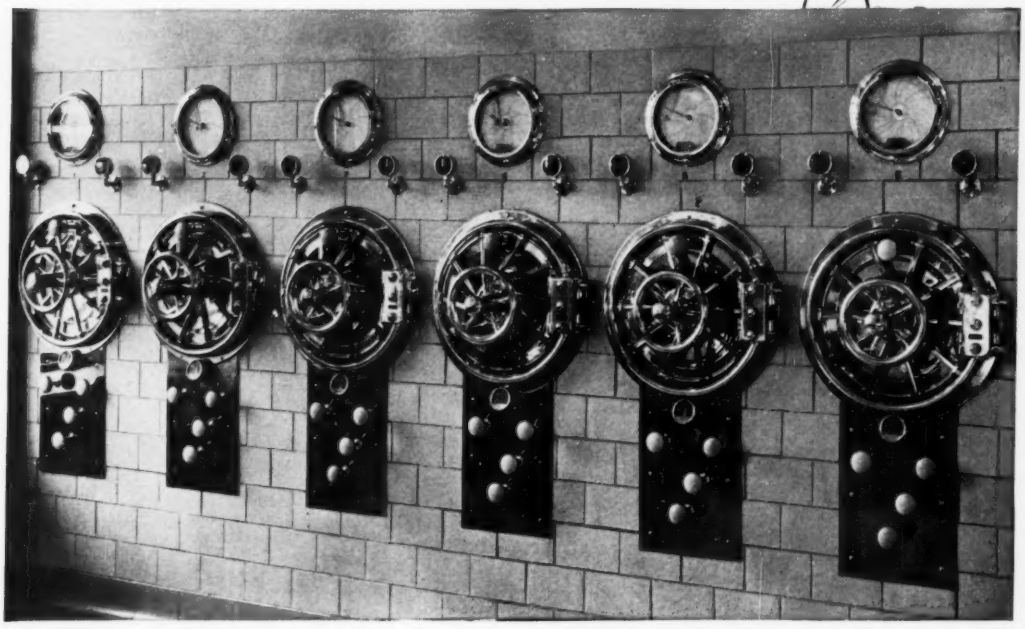
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It is the *thrifty* metal . . . may cost a little more at the outset only to cost considerably less in the long run.

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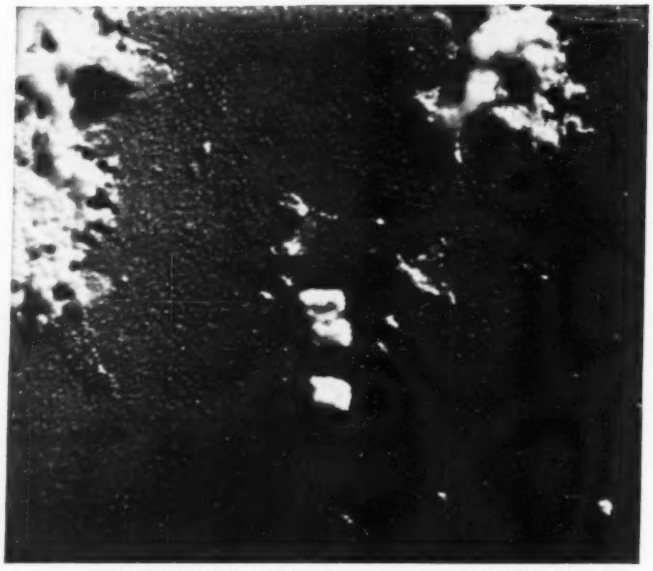
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Material here obtained from human source—with clinical and laboratory confirmation of the disease at the Squibb Institute for Medical Research.

Chicken Pox or Smallpox?

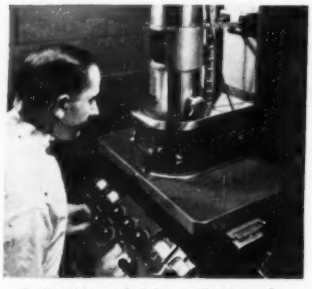
● It's SMALLPOX—*magnified 30,000 times by the RCA Electron Microscope.*

Squibb medical research uses the RCA Electron Microscope to study the virus of smallpox and many other pathogens—*because this scientific instrument reveals morphological details of the elementary bodies formerly outside the range of direct and clear observation.*

For example, the RCA Electron Microscope has helped to show the close similarity of the viruses of variola and vaccinia. It has revealed the great number of elementary bodies present in the early stages of variolous infection—and accounts for the ease with which epidemic transmission occurs. It has helped to contrast the differences in the number and size of the viruses of variola or vaccinia with the elementary bodies of varicella when obtained from vesicle fluid.

So materially has the RCA Electron Microscope contributed to the natural history of human virus diseases that it has even been suggested this instrument, in the hands of experts, can be used in *direct diagnosis*—differentiating variola and vaccinia from varicella in the prodromal and undifferentiated stage of each disease.

This is just one application of the Electron Microscope in extending the range of ultra-structure visualization for medical science. For complete information on the RCA Electron Microscope, simply write Dept. 97F, RCA Engineering Products, Camden, N. J.



A Squibb technician adjusting the RCA Electron Microscope before he photographs virus specimens. The RCA Electron Microscope magnifies up to 100,000 times—50 to 100 times more resolving power than the light microscope!

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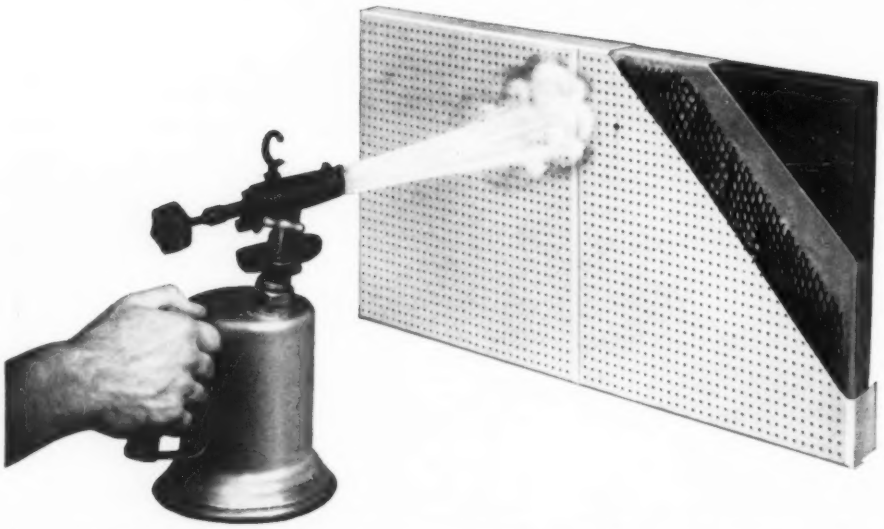
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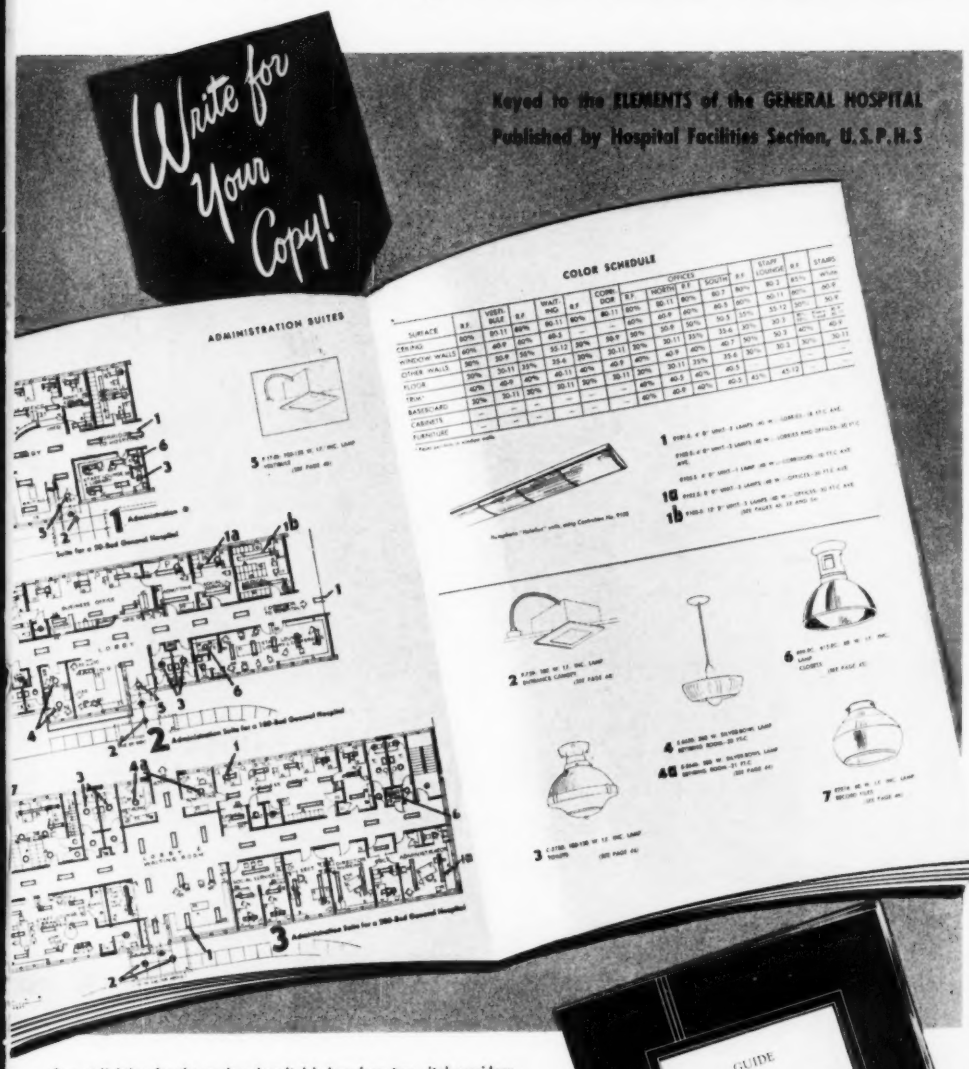
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Sick Room 2 Bed
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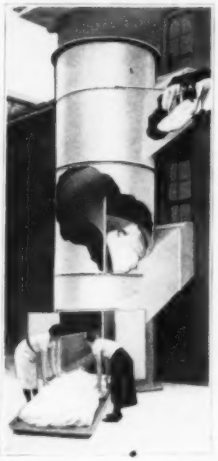
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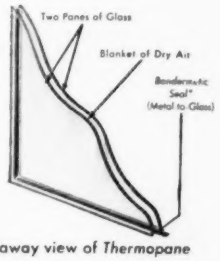


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EFFICIENCY—By test, STANLEY SERVERS keep coffee 20° hotter at the end of 2 hours than do ordinary pots. Hold temperatures—hot or cold—efficiently.

CLEANLINESS—Nickel-silver shells, stainless steel linings and wide mouths make them easy to sterilize and keep clean. All seams are air-tight, water-tight.

ECONOMY—Pay for themselves in reduced replacement. Break-proof, chip-proof, crack-proof. Extra-durable shells and hard-soldered hinges. No costly repair of spouts or handle insulators.

EASY UPKEEP—Stainless steel linings do not require replating, constant polishing. No spout cleaning problem.

FLAVOR—Get coffee to patients in better condition. Seal in aroma. Stainless steel linings eliminate metallic taste.

APPEARANCE—Add note of luxury to the little refinements that differentiate between ward and private room service.

CHARTER PATTERN ILLUSTRATED
Waldorf-Astoria Style also available
10-oz. and 20-oz. Capacity
Etched with crest or name at slight additional cost

for GENUINE STANLEYS, write . . .

STANLEY INSULATING DIVISION
LANDERS, FRARY & CLARK
New Britain · Conn.













Salad Magic

THAT BUILDS A REPUTATION!

GOOD salads are one sure signpost of a good place to eat. And since your "salad reputation" depends so greatly on the dressing you use, it is false economy to top good salad makings with less than the best!

- Prepared from famous Heinz White Vinegar, blended with selected eggs, fine oil and other choice ingredients, Heinz 57 Salad Dressing points up the flavor of your salads to perfection.
- Ask your Heinz Man to show you the many advantages of using famous Heinz 57 Salad Dressing.

Ask Your Heinz Man About

HEINZ 57

Salad Dressing

SALVAJOR *Kitchen* EQUIPMENT

Recognized for Sanitation—Proved for Savings

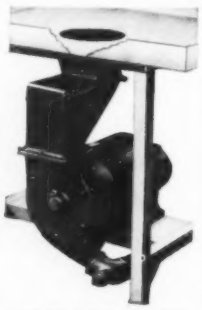


SALVAJOR SCRAPPING & PRE-WASH MACHINES

The Modern solution to dishwashing problems.

- Cuts your operating costs
- Speeds your dishwashing
- Saves your silverware
- Cuts your detergent costs
- Makes your dishes cleaner

Easily installed . . . easily maintained . . . easily operated . . . easy on the budget.



WasteXit Food Waste Disposer

- Cuts and discharges into sewerage system all waste as flowing liquid
- Helps solve fly and rat problems
- No refrigerated garbage rooms
- No garbage odors

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For Full Details

See Your Kitchen Equipment Dealer or Write Factory

THE SALVAJOR COMPANY

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An Attractive

Birthday Greeting

for Your Patients

Special Birthday paper tray appointments

- CUSTOM DESIGNED TRAY COVERS
- HOLIDAY NAPKINS & TRAY COVERS
- EVERYDAY TRAY COVERS & NAPKINS
- CHILDREN'S TRAY COVERS

Special birthday trays are always sure to please your patients. Aatell & Jones paper birthday tray appointments — napkins and tray covers — make the day really special.

Bright, cheerful surroundings do much in speeding a patient's recovery. Aatell & Jones holiday and Sunday paper tray appointments, through their lively and colorful designs, lift patients' morale. They mean more sanitary service, too, with a clean new tray cover for each serving.

Order NOW for immediate delivery.

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HOSPITALS RELY ON EQUIPMENT FROM PIX



ALBERT PICK CO., INC.

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CRACKED ICE CART

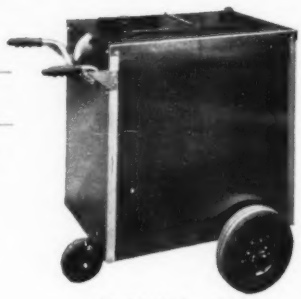
ALL STAINLESS STEEL

150 lb. Storage—
Heavy Duty
Rubber Wheels—
Three Inches
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Immediate Delivery

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Model XV Ice Cart
For Storage and Mobility
All Stainless Steel

Write for Catalogue

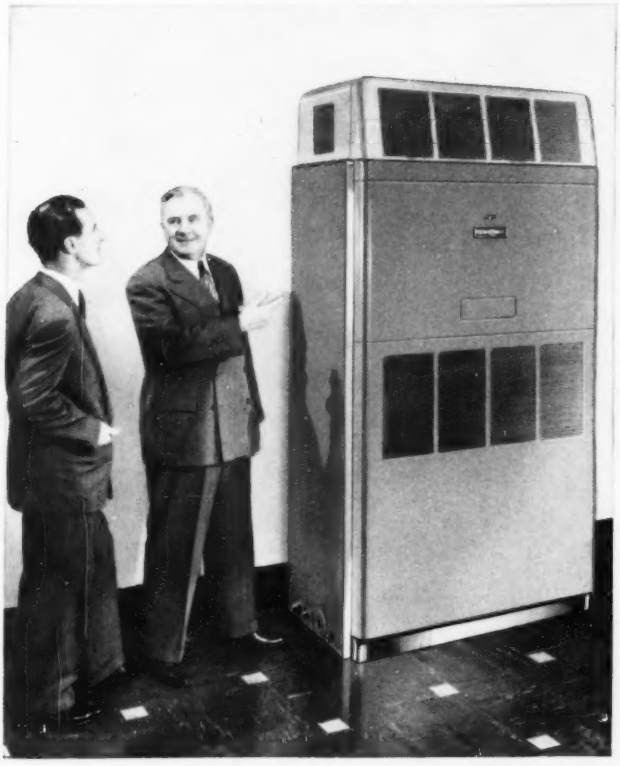
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GENNETT & SONS, INC.

RICHMOND INDIANA

A smart, new air conditioner
at a wonderful, new low price...

The New Frigidaire Self-Contained Air Conditioner!



This wonderful new, completely self-contained Frigidaire Air Conditioner can be quickly installed almost anywhere. Its two-tone gray finish and smartly modern Raymond Loewy styling blend with any surroundings. And its new low price makes it far and away today's finest buy in air conditioning.

Every part of the air conditioning mechanism has been designed and built by Frigidaire. Special Frigidaire design gives you selective control of the airflow—on all four sides. Heavy, expertly-applied insulation keeps noise inside—prevents moisture from forming outside. And, best of all, the famous Frigidaire Multipath cooling unit, rugged compressor, and controls are precision-matched to work like a championship team—give you years and years of low-cost, trouble-free service.

For full information about Frigidaire Air Conditioners, see your dependable Frigidaire Dealer. He'll be glad to survey your air conditioning needs without obligation. Find his name in Classified Phone Book, under "Air Conditioning" or "Refrigeration Equipment". Or write Frigidaire Division of General Motors, Dayton 1, O. (In Canada, Leaside 12, Ont.)



Frigidaire Room Air Conditioners—*at new low prices*—are easily installed. These self-contained units supply plenty of cool, clean, dehumidified air for rooms in homes, offices, hotels, hospitals.



Frigidaire Central Systems offer capacities, types and sizes to fit almost any air conditioning need—regardless of the size or shape of the area to be conditioned.

Exclusive MULTIPATH Cooling Means—

1. **Smooth, uniform cooling.** Scientifically metered flow of refrigerant to all parts of the cooling unit assures even temperature throughout the coil.

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FRIGIDAIRE
Air Conditioning

Over 400 Frigidaire commercial refrigeration and air conditioning products—most complete line in the industry.

The "Fresh Up" Family Drink!

So pure... So good... So wholesome for everyone!



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Sure... you can turn the hose on it.





They are Patented

The many valuable advantages of Ideal special design and construction cannot be found in any other unit. These priceless results of Ideal research, study and long experience are fully protected by patents in the United States, Canada and overseas countries.



Hospital standards of sanitation and cleanness are designed and built right into every Ideal Food Conveyor. Though we don't advocate it, you can use a hose or a steam jet on any Ideal with little concern about damage. Heating elements, control devices are well protected by Ideal methods of assembling top deck and food wells.

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Ideal labor-saving cleanness is available in many models, sizes and materials. You can select an Ideal to exactly fit both budget and service needs. Write for catalog and specification data.

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Found in Foremost Hospitals



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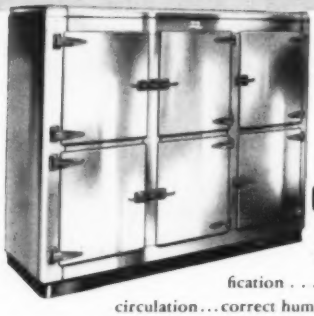
In the big, block-long DON BUILDING is every facility to serve your needs better and faster. DON regularly sells 50,000 items such as glassware, chinaware, pots, pans, furniture, kitchen utensils, bar supplies, fountain supplies, janitorial and sanitation supplies. On every item, SATISFACTION GUARANTEED OR YOUR MONEY BACK!

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Assures You

COMPLETE FOOD CONDITIONING

Thorough air purification . . . gentle yet positive circulation . . . correct humidity and controlled temperature mean fresher, more flavorful food. These are all important "plus-features" of every HERRICK refrigerator. To assure you easy, carefree sanitation, HERRICK refrigerators are finished, *inside and out*, with wear-proof stainless steel. Write for full information.

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HERRICK *The Aristocrat of Refrigerators*

Hasco Stainless Steel
CRUSHED ICE CHESTS

THREE INCHES OF FIBRE GLASS INSULATION



Electrically welded into one solid piece.

CAP. 125 lbs.
Has Stainless Steel interior. Cabinet Size is 24" wide, 20" deep, 41" high including 6" removable legs.
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$153.75

CAP. 175 lbs.
Counterbalanced, Stainless Steel Tilt Bin. Removable.
Outside Dim. 26" wide x 22" deep x 42". Bin size 20⅛" x 16½" x 24¼".
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Height 31", width 25⅛", depth 14⅛". All doors efficiently sealed with molded rubber gaskets. Air vents in back of storage compartment eliminate odors.
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Optimal Nutrition

SO VITAL FOR OPTIMAL HEALTH

In the achievement and maintenance of optimal health, no other single influence looms so vital as sound nutrition. In fact, so important is this principle to preventive medicine that *optimal nutrition* is now the basis of all health programs.

When nutritional health is threatened, as in dietary restrictions imposed by disease, or when the nutrient intake is insufficient because of other reasons, the *multiple dietary supplement* Ovaltine in milk is especially useful for overcoming nutrient deficiencies of the diet.

Three glassfuls daily may readily supplement even poor diets to adequacy. Easy digestibility makes its many valuable nutrients —vitamins, minerals, biologically complete protein—and its food energy quickly available. The pleasing flavor adds to its wide applicability and usefulness.

The table below gives the amounts of nutrients in three glassfuls of Ovaltine in milk.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine



Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide.

CALORIES	676	VITAMIN A	3000 I.U.
PROTEIN	32 Gm.	VITAMIN B_1	1.16 mg.
FAT	32 Gm.	RIBOFLAVIN	2.0 mg.
CARBOHYDRATE	65 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12 mg.	COPPER	0.5 mg.

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.



THROAT SPECIALISTS PROVE CAMEL MILDNESS IN 30-DAY SMOKING TEST



● In a recent coast-to-coast test, hundreds of men and women smoked Camels—and only Camels—for thirty consecutive days. They smoked on the average of one to two packages of Camels a day. Each week during the entire test period, the throats of these Camel smokers were examined by throat specialists. A total of 2,470 careful examinations were made. And after correlating these case histories, the throat specialists reported

"NOT ONE SINGLE CASE OF THROAT IRRITATION due to smoking CAMELS."

MONEY-BACK GUARANTEE!

Try Camels and test them as you smoke them. If, at any time, you are not convinced that Camels are the best cigarette you've ever smoked, return the package with the unused Camels and you will receive its full purchase price, plus postage. (Signed) R. J. Reynolds Tobacco Co., Winston-Salem, N. C.



According to a Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

When three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel.

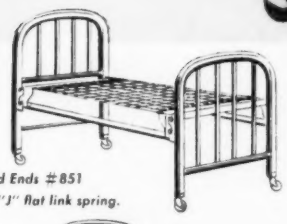
NONE FINER MADE!

FOSTER *Ideal*

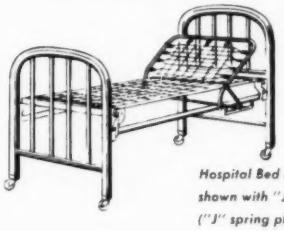
HOSPITAL SLEEP EQUIPMENT FOR EVERY REQUIREMENT



Pictured bed is Foster #851-3 Hospital Model. This bed shows #3 Crank Adjustable Spring, #10 Adjustable Bedsides that fit either side, and special Hospital Innerspring Mattress. Irrigator Rod shown can be readily placed at head or foot of bed or easily changed from one bed to another. #851 Bed Ends are 1¾ in. Victorian, electric welded tubing. Inside length between posts, 6 ft. 7 in. Stock finish, grained walnut. Comes equipped with 3 in. rubber composition casters. Shipping Weight – 250 lbs. complete as shown.



Hospital Bed Ends #851 shown with "J" flat link spring.



Hospital Bed Ends #851 shown with "JB" spring ("J" spring plus backrest)

"A DEPENDABLE SOURCE OF BEDDING PRODUCTS SINCE 1871"

Write for new catalog #149 showing complete Foster hospital line.

SEE OUR PERMANENT DISPLAY ONE PARK AVE., N. Y. 16, N. Y.

FOSTER BROS. MFG. CO.

UTICA, N. Y. ST. LOUIS, MO.

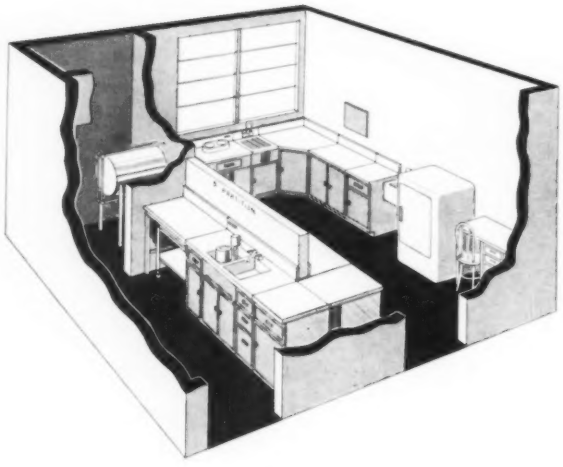
moduline

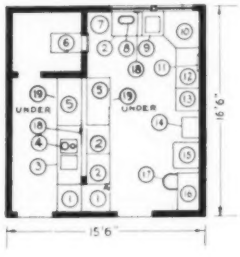
meets every hospital need

the most modern hospital furniture in the world

With Moduline you can provide furniture for your milk formula room, nurses' stations and laboratory rooms, that will meet your needs for years to come. Moduline, by Aloe, is styled for tomorrow. It comes in architecturally approved widths and depths so that custom-built facilities may be developed from standard Moduline units. Here are some characteristic details: concealed hinges, baked steel finishes with stainless steel table tops. Utilities can be top or splashback mounted. Write for special booklet T-300 and learn how Moduline can meet your furniture needs.

Special Schematic Layouts for Hospital installation available on request.





MILK FORMULA ROOM FOR A GENERAL HOSPITAL

EQUIPMENT LEGEND

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1. 85L-24D—Drawer-Cupboard Unit without Splashback
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2. 85L-D35—Table Top Units with 85X-27 Legs (3 Prs. Required)
3. 85L-72AS—Double Sink Unit
5. 85C-47—Counter Top Units with 85X-27 Legs (2 Prs. Required)
6. 85L2238M—Milk Formula Sterilizer
9. 85L-24AS—Sink Unit with Stainless Steel Grill
10. 85L-39—Corner Unit
11. Bulletin Board
12. 85L-35—Cupboard Unit
13. 85L-24D—Drawer-Cupboard Unit
14. Lavatory
18. 85ES-2—Electrical Duplex Plug Strip

GROUP 2 (NOT FIXED)

4. Olson Bottle Washer
7. 85P6398AL—Waste Receptacle-Silver lustre Finish
8. 85P5363—Double Element Hot Plate
15. Refrigerator
16. 85P6238—Nurses' Desk—Silver lustre Finish
17. 85P6327AL—Chair—Silver lustre Finish
19. 85P6356—Milk Cart

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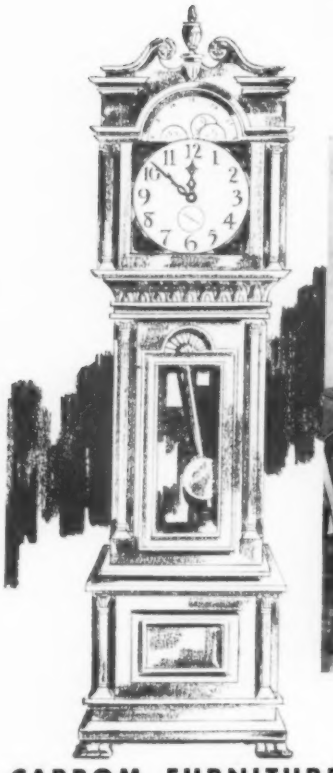
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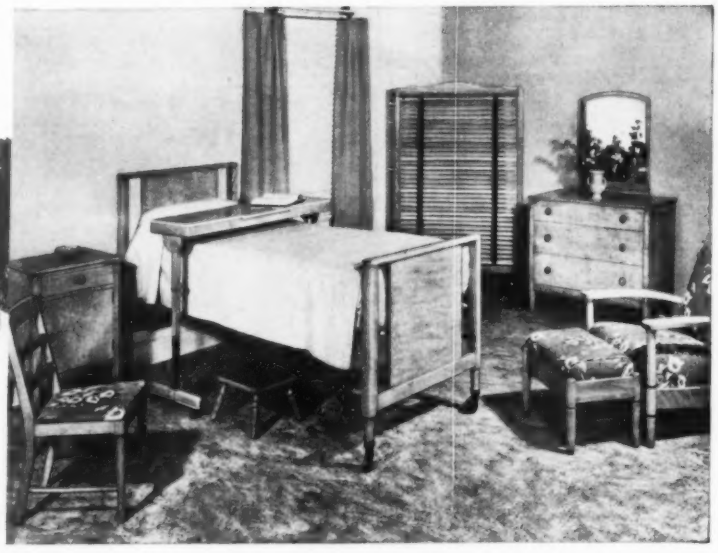
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CARROM SUITE "B", Swedish Modern. Its modified Swedish Modern theme gives it a simple and lasting charm that will always be in good taste. Solidly built, beautifully finished, artistically styled.

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It is not enough that the material used for institutional furniture possess a mechanical strength of *highest* value in its ability to resist bending or compression. It should also possess that intimate and appealing beauty we sometimes define as grace and charm.

Wood is the one material — and the only material — that meets both these requirements. It is the one material of great strength that lends itself to an ease of manipulation that makes possible basic harmony and graceful lines in the finished furniture product.

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Safety sides lower to level of spring. Sides extra-deep, so child cannot fall or climb out. Closely spaced upright filling rods, so child cannot force head through open spaces.

Sides cannot be lowered by child in crib or on floor, but are easily operated by attendant, who presses pedal and simultaneously lifts side. For details of this and other hospital furniture, write:

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(for all disc-type floor machines)

provide a quicker, safer finish

THE WILLIAMS COMPANY—*Steel Wool Products* MH-649
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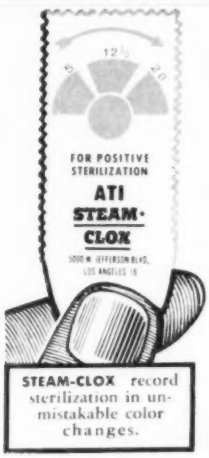
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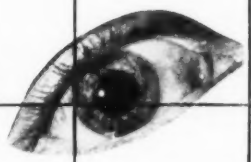
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STEAM-CLOX make your hospital error-proof in this vital department, and at a cost of only 2½c per pack. Write today for ample free supply for proving in your own autoclave. See for yourself why so many hospitals use STEAM-CLOX.

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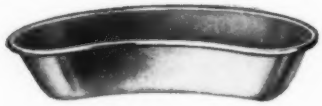
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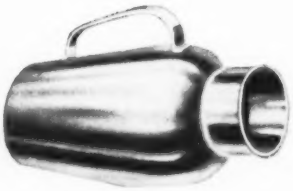
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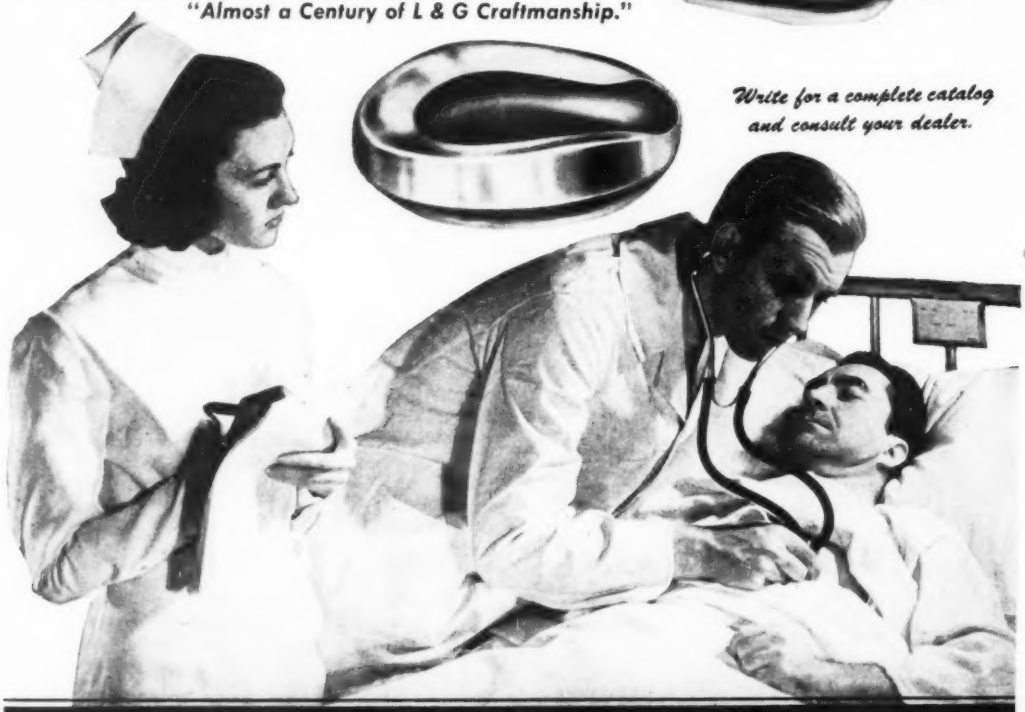
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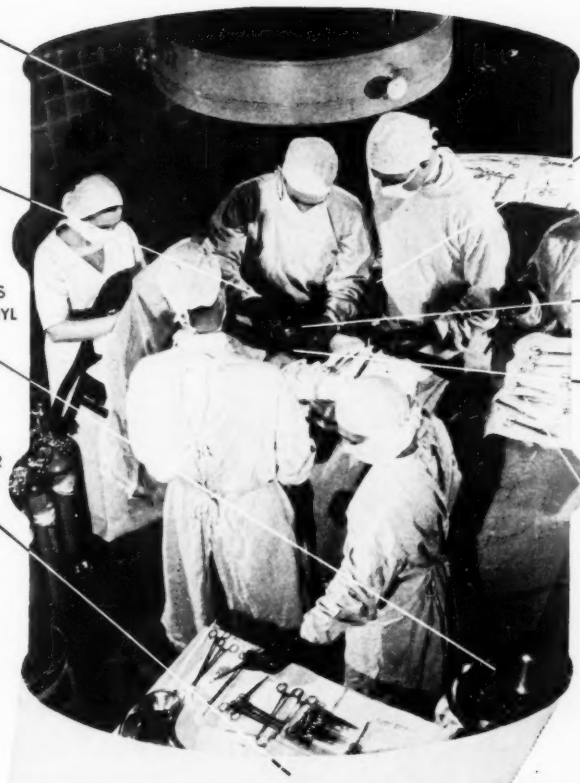
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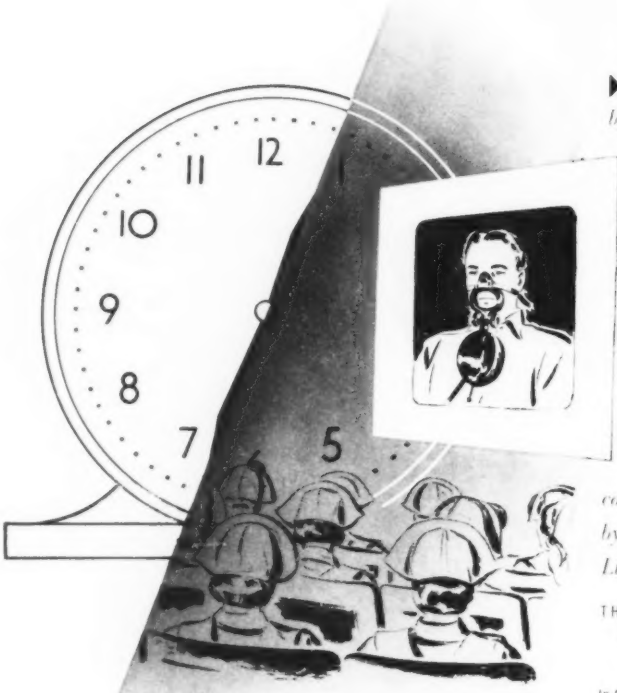
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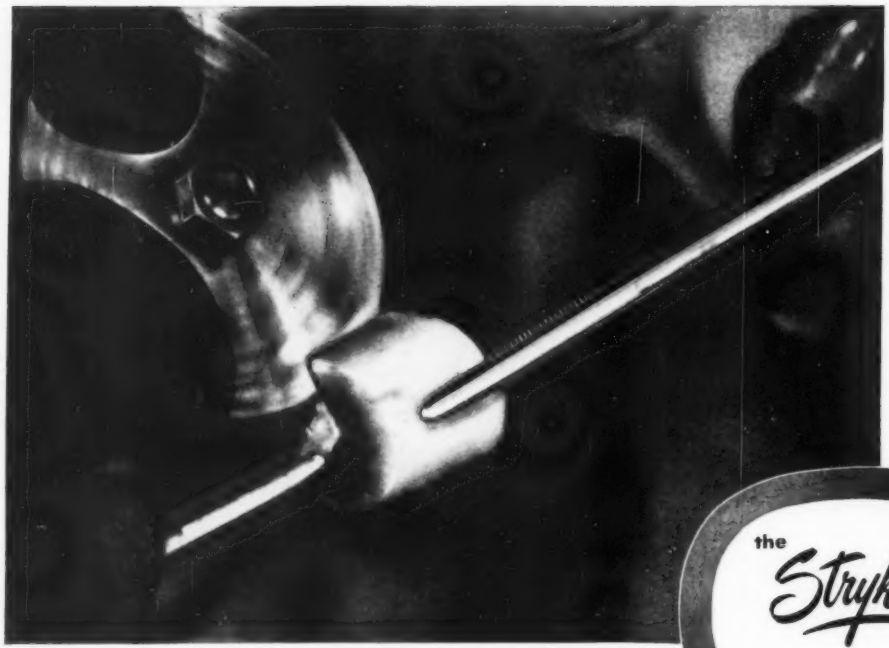
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(Continued on page 210)

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(Continued on page 212)

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LIBRARIAN—Chief medical record; for university hospital; must be registered and experienced in both clinic and private record room operations; must have supervisory ability; general hospital of 400 beds and outpatient department with yearly census of 116,000 visits. Apply, Personnel Department, Stanford University Hospitals, Clay and Webster Streets, San Francisco 15, California.

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MISCELLANEOUS—Nurse science instructor; capable of teaching anatomy and pharmacology for university credit; operating room nurses with post-graduate work; general staff nurses for medicine, surgery, obstetrics and communicable diseases; permanent positions open also for vacation relief. Apply, Director of Nursing, Evanston Hospital, Evanston, Illinois.

MISCELLANEOUS—Staff Nurses and Supervisors; unique opportunities in progressive program for psychiatric patients; modern nurses' home; many recreational facilities; excellent educational program; promotional opportunities; automatic increases; maintenance optional; liberal vacation and illness policies; hospital and group insurance; 8-hour day, no split shifts; 11 holidays; graduate nurse $2340-$2700; head nurse $2580-$2940; supervisor $2820-$3420. Apply, Director of Nursing, Norwich State Hospital, Norwich, Connecticut.

MISCELLANEOUS—Staff nurses; for 550-bed hospital; salary competitive; 44-hour week; 10 days' paid sick leave, 2 weeks' vacation and 8 holidays annually; increases annually on merit basis; maintenance may be had at a reasonable cost; also positions for qualified supervisors. Apply, Director of Nurses, Kansas City General Hospital, Kansas City, Missouri.

NURSES—Graduate; for 475-bed hospital; salary open. Apply, St. Barnabas Hospital for Chronic Diseases, 183rd Street & 3rd Avenue, New York 57, New York.

(Continued on page 214)

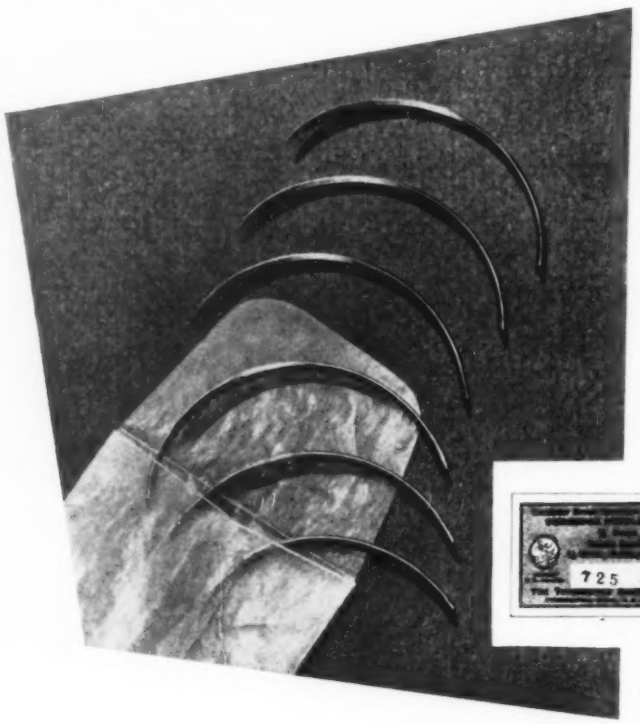
NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Obstetrical; California hospital on San Francisco Bay; forty minutes from that city; five-day week; salary $225.00 per month if post graduate or experienced; $10.00 additional for evening and night hours; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Operating room; for 500-bed hospital; 44-hour week; minimum salary $180; automatic raises every six months for 24 months; $10 differential for surgery nurses after 1 year experience. Apply Director of Nursing, The Buffalo General Hospital, Buffalo 3, New York.

NURSES—Registered; for 200-bed tuberculosis hospital; good salary, plus room, board and laundry. Apply, Superintendent, Indiana State Sanatorium, Rockville, Indiana.

NURSES—Registered; all floors; straight shifts; matrimony has depleted our staff; beginning salary $225 per month; raises at six month periods for two years; maintenance at reasonable rates if desired; additional pay for surgery; also for evening and night shifts; pleasant working conditions; nearly new, well equipped hospital. Municipal Hospital, Clarinda, Iowa.



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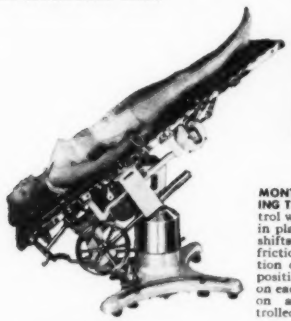
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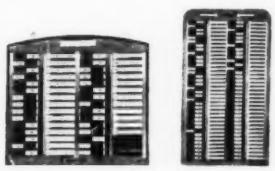
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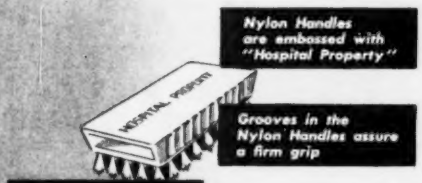


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NURSES—General staff; $170 plus meals; $10 increase every six months for 2 years; 2 weeks' vacation; 2 weeks' sick leave. Write, Hamilton County Public Hospital, Webster City, Iowa.

NURSES—Graduate; salaries ranging from $195 to $295 depending upon experience and training; civil service tenure, paid vacation, retirement benefits; work in mental and tuberculosis hospitals. Write to Michigan Civil Service Commission, 220 N. Grand Avenue, Lansing, Michigan.

NURSE—Operating room; salary open; also general duty nurses for medical, surgical and obstetrical departments; 50-bed hospital located in university city, central Ohio; vacation; sick leaves and full maintenance allowed. Apply, Superintendent, Jane Case Hospital, Delaware, Ohio.

NURSES—Registered; for staff duty in a general hospital; all departments including operating room; beginning salary $180; 40-hour week; $10 additional for permanent evening and night duty; also, openings for two head nurses and one nurse with pediatric training; instructor to supervise practical nurse students in the clinical field and act as co-ordinator for the practical nurse school and hospital programs; desirable living and working conditions; educational advantages. Apply, Director of Nursing, Tompkins County Memorial Hospital, Ithaca, New York.

NURSES—Two; for 25-bed United Church Mission hospital on British Columbia coast; salary begins at $120 per month and maintenance; 5 weeks annual holiday; travelling allowance. Apply, General Hospital, Bella Coola, British Columbia.

OCCUPATIONAL THERAPISTS—Graduate, registered; trained recreation workers for assignment in Illinois state psychiatric hospitals; schools for mental defectives; children's and correctional institutions; civil service positions; career service with opportunity for advancement; good salaries; excellent retirement and insurance plan; maintenance available if desired. Applicants may contact Miss Bertha E. Schlotter, Room 1500, 160 N. LaSalle Street, Chicago 1, Illinois.

PHARMACIST—Pontiac General Hospital, Pontiac, Michigan; excellent opportunity all phases hospital pharmacy; regular 44-hour week; two weeks vacation; liberal sick leave and holidays; civil service tenure after working test period; city retirement plan, other advantages; close to Detroit, salary $270-$320 per month, regular increases; maintenance available at nominal charges. Write Personnel Director, Pontiac General Hospital, Pontiac 18, Michigan for official application.

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SUPERVISOR OF NURSES—Assistant; for 200-bed tuberculosis hospital; good salary, plus room, board and laundry; send photograph; state qualifications and personal details. Apply, Superintendent, Indiana State Sanatorium, Rockville, Indiana.

SUPERVISOR—Operating Room; immediate opening; good location; state capitol with many civic advantages; salary is open. Apply, Director of Nurses, Bismarck Evangelical Hospital, Bismarck, North Dakota.

(Continued on page 216)

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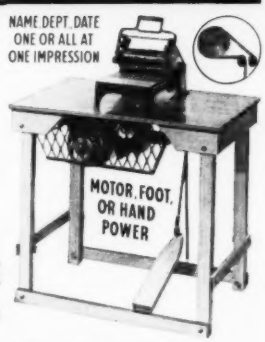
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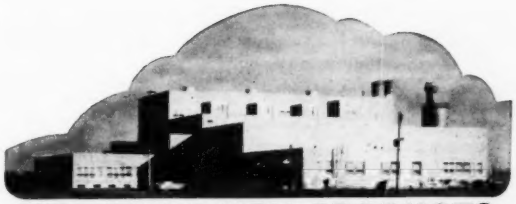


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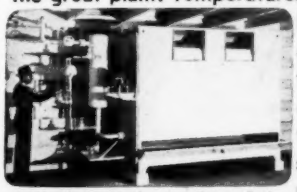
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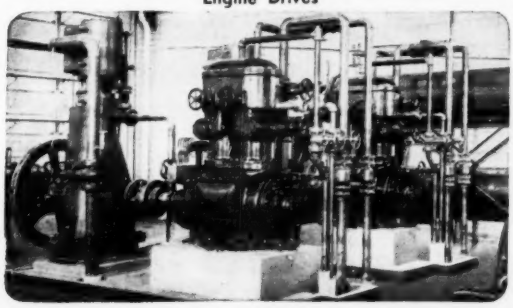

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SUPERVISOR Operating room: for large operating room department of general hospital; experience in operating room management necessary; 44-hour week; liberal vacation and sick leave allowance; salary open depending upon qualifications and experience of applicant. Apply, Director of Nurses, Michael Reese Hospital, Chicago, Illinois.

SUPERVISOR Operating room: for 200-bed fully approved Nebraska hospital; Protestant; $225 and full maintenance; needed immediately. MO 52, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR—Pediatric: for 465-bed hospital with 39-bed pediatric department; school has a college affiliation; salary commensurate with preparation and experience; attractive nurses' residence; living in optional; four weeks vacation; 44-hour week; retirement plan. Apply, Director of Nurses, The Reading Hospital, Reading, Pennsylvania.

TECHNICIAN—Laboratory and X-ray: for busy small general hospital near Madison, Wisconsin; must be well qualified; salary open but good; complete maintenance. MO 48, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

TECHNICIAN—Laboratory: for general work in 85-bed hospital; experienced and registered; salary dependent on qualifications. Apply, Sister Theresa Agnes, Superior, St. Mary's Hospital, Astoria, Oregon.

TECHNICIAN—Medical laboratory; registration preferred; for 200-bed tuberculosis hospital; good salary, plus room, board and laundry; send photograph; state qualifications and personal details. Apply, Superintendent, Indiana State Sanatorium, Rockville, Indiana.

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(Continued on page 218)

INTERSTATE—*Continued*

SUPERINTENDENT—(a) R.N.; 50-bed hospital; near Chicago. (b) 65-bed Kentucky hospital. (c) 40-bed Ohio hospital; $350. (d) Small Maryland hospital.

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INSTRUCTORS—(a) Science; 200-bed hospital, near Philadelphia. (b) Nursing arts; 300-bed hospital; university city; mid-west. (c) Clinical, medical, surgical, obstetrical; 400-bed hospital; east. (d) Social sciences; 300-bed hospital; Wisconsin. (e) Public health; $4000; east, midwest, southwest.

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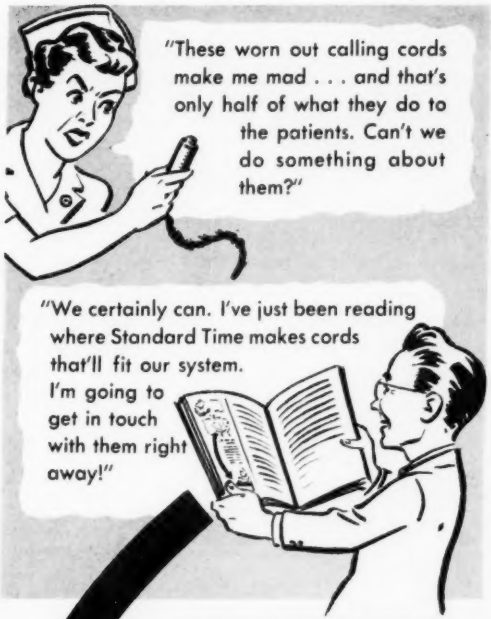




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INTERSTATE—*Continued*

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PUBLIC RELATIONS DIRECTOR—General 300-bed hospital; university medical center, east. MH6-2

ADMINISTRATORS-NURSES—(a) General hospital, 150 beds; would serve as assistant administrator until established; east. (b) Small general hospital now being constructed in textile community short distance from large city; south. MH6-3

ANESTHETISTS—(a) General hospital; new hospital to be built within year; staff of four anesthetists; Chicago area; $300, maintenance. (b) New hospital to be opened within month on campus of university; quarters available in women's dormitory; minimum $300, meals, laundry; south. (c) New hospital, beautifully located in Alaska; should be experienced in thoracic surgery; $300-$350, maintenance. MH6-4

DIRECTOR OF NURSES—(a) 500-bed hospital; medical school affiliation; university medical center; east; $5000-$6000. (b) Large teaching hospital; university center; preferably one who has lived in south; $5000-$6000. (c) One of most important appointments in nursing profession; nationally known teaching hospital; well staffed department; $600, maintenance. (d) Fairly large hospital considered one of most important in California. (e) New hospital in South America operated under American auspices; no school; knowledge of Spanish required; minimum $6000. (f) General hospital, 150 beds, affiliated with 12-man group; all-graduate staff; winter resort city, south. (g) Large hospital specializing in care of nervous and mental diseases; training program for affiliate nurses, attendants; $5000. (h) Assistant director of nursing service; teaching hospital; delightful location, completely furnished private suite provided in beautiful new apartment building. MH6-5

FACULTY APPOINTMENTS—(a) Educational director and, also, nursing arts instructor; large voluntary hospital, beautifully located in eastern state near university center; minimum salaries $4500 and $3600 respectively. (b) Science instructor; general hospital, 250 beds; college affiliation; fairly large town, short distance from New York city; $250-$300, maintenance. (c) Educational director; affiliate school; 300 students; tuberculosis experience desirable; $4500, increasing. (d) Psychiatric instructor; psychiatric unit of modern, well equipped hospital; $400, complete maintenance; outside continental United States. (e) Instructors in clinical teaching; university hospital; appointments carry academic rank on university faculty; interesting set-up. (f) Educational director to establish and conduct program in nursing; liberal arts college; rank: associate or full professor; $5000-$6000. MH6-6

(Continued on page 220)

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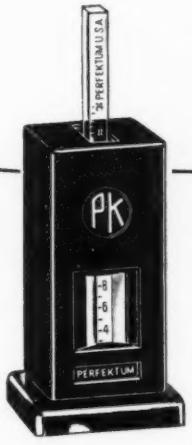
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(Continued on page 222)

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(Continued on page 224)



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(Continued on page 226)

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(Continued on page 228)

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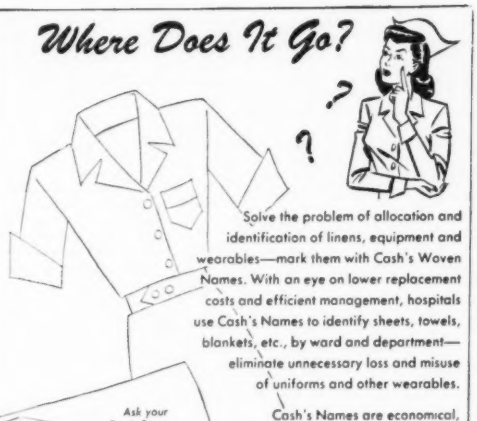


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JERSEY CITY MEDICAL CENTER SCHOOL OF NURSING offers to qualified graduate nurses a four-month course in operating room technic. Full maintenance and stipend granted. Apply to Director of Nurses, Jersey City Medical Center, Jersey City, N. J.

SCHOOLS—SPECIAL INSTRUCTION

Skidmore College, in association with the New York University-Bellevue Medical Center of New York University, University Hospital, offers to graduates of accredited schools of nursing, supplementary programs in management and teaching and in operating room technique. Admission dates for seven months' operating room program are the fifteenth day of March and September. Students are admitted for one year program in unit management and teaching the first Monday in October. For details write Director, School of Nursing, 303 East 20th Street, New York 3, New York.

MERCY COLLEGE SCHOOL OF ANESTHESIA

Offers a twelve-month course in Anesthesiology to graduates of accredited Schools of Nursing. The course includes didactic and clinical experience in all inhalation, intravenous and rectal anesthetics; and in the therapeutic gases: helium, oxygen and carbon dioxide. Classes are admitted the first of January and September. Apply to Director, Department of Anesthesia, Mount Carmel Mercy Hospital, 6071 West Outer Drive, Detroit 21, Michigan.

(Continued on page 230)

The MARGARET HAGUE MATERNITY HOSPITAL. The largest hospital in the country offers the following to registered, professional nurses of accredited schools:
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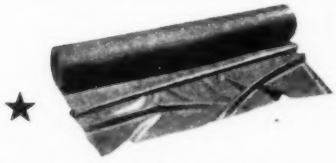
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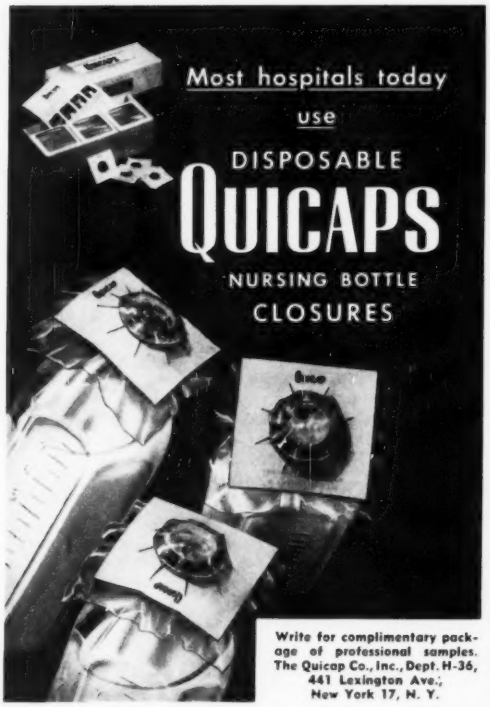
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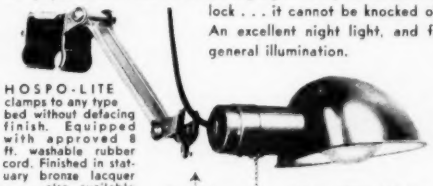
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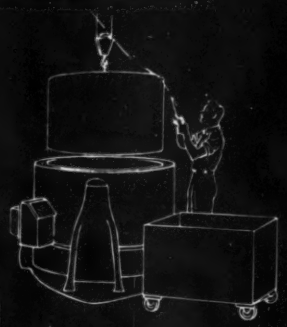
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Soiled TRI-PADS can be replaced in a second . . . takes several minutes to replace bed linen and remake a bed.



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TRI-PADS cost less than average hospital-made pad.

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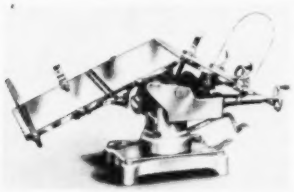
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What's New for Hospitals

JUNE 1949 Edited by BESSIE COVERT

Hermann Operating Table

In the new Hermann major operating table the most important controls are within comfortable reach of the anesthetist. The table permits exaggerated kidney position and extremely low minimum height in all operating positions. In the extreme kidney position, for instance, the peak of the angle can be placed at a minimum height of 32 inches, thereby avoiding the use of a foot stool for the surgeon.



The top of the table, which is of heavy gauge stainless steel and divided into 5 independently adjustable sections, may be adjusted from a 35 degree Trendelenburg to a 30 degree reverse Trendelenburg by means of the left hand wheel at the head end. The single control operated by the right hand head-end wheel adjusts the top from the extreme kidney to the reflex abdominal position and vice versa without other controls. In the chair position, also controlled by a head-end wheel, the seat is at the low height of 26 inches. Accessories and fittings for the table are finished in chromium plate and the base is in Silverlux enamel. **Shampaine Company, Dept. MH, 1920 S. Jefferson Ave., St. Louis 4, Mo. (Key No. 683)**

Putty and Accessories

Caulking putty is now available in cartridge form, each cartridge containing approximately 1/10 gallon, packed 24 cartridges to the carton. A caulking putty in a new tan color has also been developed for use around buildings where exterior materials are of tan, red, brown or other warm color. Caulking putty in the new color is available in cartridge form as well as in cans or drums.

A new caulking gun of sturdy metal construction has been designed to take either cartridges or putty in bulk form. The nozzle and grip assembly are detachable so the barrel can be quickly and easily cleaned and the barrel is 2⅛ inches in diameter by 9½ inches long. **Johns-Manville, Dept. MH, 22 E. 40th St., New York 16. (Key No. 684)**

Blood Typing Board

Dr. Ivan Brown of the Duke University Hospital Blood Bank has developed the Brown Blood Grouping and Cross Matching Board to increase efficiency and eliminate technical and clerical errors in blood grouping and cross matching. Incorporating all the latest approved technics of blood grouping, Rh typing, Rh sensitivity testing and cross matching for transfusion, simplifying and combining them in orderly sequence, the Board permits accurate testing by personnel not primarily concerned with this type of work. **Clay-Adams Co., Inc., Dept. MH, 141 E. 25th St., New York 10. (Key No. 685)**

Tile Flooring

The result of years of research and experiment, Armstrong's new Corlon floor tile is made of a chemically reacted combination of plastics and is highly resistant to wear. The new tile has high grease resistance and high resistance to indentation. It is available in 10 rich colors, marbleized, and known as Gardenia White, Pewter Gray, Jet Black, Venetian Red, Desert Tan, Walnut Brown, Twilight Blue, Sand Taupe, Spruce Green and Wine Red. It is made in 4 sizes: 6, 9, and 12 inch squares and 18 by 36 inch rectangles, all in ⅛ inch gauge. **Armstrong Cork Co., Dept. MH, Lancaster, Pa. (Key No. 686)**

Plastic Toilet Seat

The Models LP-20 and LP-40 self-raising and self-sustaining hinge construction toilet seats are now available in white solid plastic. The new seats are said not to chip, peel, fade or wear and to retain the original luster when washed with soap and water. Hinge construction on both models is plastic covered and sealed against moisture and dirt. **Sperzel Co., Dept. MH, 123 Fourteenth Ave. S., Minneapolis 4, Minn. (Key No. 687)**

Boiler for Coal or Oil

The new Crane 30 boiler is a medium-sized unit, for small hospitals or other institutions, which burns coal or oil and may be fired manually or automatically. For hand firing the boiler is equipped with a gear-shift shaking mechanism that prevents accidental dumping of the fire.

Features of the new unit include a corrugated multiple-pass flue design that presents a maximum area to the fire and hot gases, patented baffles for controlled water travel, large fuel capacity and precision-ground sections for close true fit. The fire door has a new secondary air feature for close control of air over the fire. The boiler is available in sizes from 6 to 16 sections with net I-B-R ratings from 180,000 Btu per hour to 792,000 Btu per hour. **Crane Co., Dept. MH, 836 S. Michigan Ave., Chicago 5. (Key No. 688)**

Oil Fired Bakery Oven

A new economical oil fired oven called "Vapor Heat" has recently been announced. Simple and convenient to operate with no resulting odors, smoke or soot, it burns ½ to 1 gallon per hour of clear No. 1 Distillate, kerosene or clear gas oil. The burner system, with an aluminized steel sheet interior and insulated throughout with Fiberglas, is thermostatically controlled. There are no tubes or combustion chambers to heat up and the unit is economical in operation. The average 18 bun pan oven will reach full temperature of 425 degrees F. in 20 minutes and when fully loaded with



bread the temperature drops only 4 to 6 degrees F., recovering to controlling temperature in 5 minutes. **Despatch Oven Co., Dept. MH, 619 S. E. 8th, Minneapolis 14, Minn. (Key No. 689)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

Metal Stands and Tables



A complete line of utility tables of stainless steel, Surgalum or Silverlux finish has been developed by American Hospital Supply Corp. The Tomac Anesthesia Table illustrated was designed for convenience and efficiency. Other items in the line include a utility table, work tables, general utility carriage, wall stands and the like. Clean, functional lines, light weight, absence of tight corners and deep crevices and sturdy construction are features of the new equipment which is easily cleaned, attractive in appearance and efficient in use. All items are equipped with ball-bearing casters. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 690)**

Inter-Communication System

The new "Chief Forty-Niner" intercommunication system has special features increasing its flexibility and adaptability. The "Dynasonic Selector" is a feature designed to make the one model meet all requirements by furnishing optional performance for each unit in the system. The user selects the type of performance desired of each unit and may change his selection as requirements indicate. Six, 20 and 30 capacity Master Stations can be used in the same system and can be intermixed with Staff Stations.

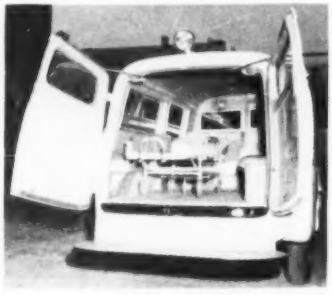
Another feature of the new system is the Multi-Matic Selector which provides 12, 20 and 30 station capacity with only 12 push buttons. The manufacturer states that the system is Underwriters' Laboratories approved and is adaptable for large or small institutions. **Talk-A-Phone Co., Dept. MH, 1512 S. Pulaski Rd., Chicago 23. (Key No. 691)**

Duo-Cut Tile

Fremont Rubber Tile is now available in a form which facilitates attractive floor designs. Regular 9 by 9 inch squares of rubber floor tile are bevel die cut so that a 6 by 6 inch square can be readily removed from the inside and an insert of another color substituted. Known as Duo-Cut, these specially cut tiles afford many possibilities in pattern designing and color schemes since the tile is available in 13 plain and marbleized colors. **Fremont Rubber Co., Dept. MH, 105 McPherson Highway, Fremont, Ohio. (Key No. 692)**

Franklin Ambulance

The new Franklin ambulance body, designed for Ford, Chevrolet and other lighter weight chassis, offers ambulance facilities at low purchase and maintenance costs. The body is equipped with safety glass windows, linoleum or rubber matting floor, 3 point stretcher suspension on ceiling, static ventilator with grille in roof, dome lights in front and rear compartments, electric fan for extra ventilation, medicine and utility cabinet, invalid chair-cot with rubber tires and device for fastening to the ambulance while in transit as well as red side lights, three-way visibility and a siren and flasher on the roof in front. It is constructed for safety and service and has



modern, streamlined design. **Franklin Body & Equipment Corp., Dept. MH, 1042 Dean St., Brooklyn 16, N.Y. (Key No. 693)**

Radio Headset

A new headset for individual listening to radio programs has been introduced under the name Twinset and weighs only 1.6 ounces. It can be comfortably adjusted to any head size and worn without any part touching the ear. Designed for comfort, the Twinset is equipped with nickel sound arms that can be individually adjusted so that only small, plastic eartips enter the ear openings without putting pressure on any part of the ear. Miniature magnetic receivers connected to each adjustable sound arm deliver a pure tone directly into the ear canal. The headset is equipped with a single cord connection for plugging into all standard jacks. The unit is especially designed for use in hospitals. **Telex, Inc., Dept. MH, 1370 Northwestern Bank Bldg., Minneapolis 6, Minn. (Key No. 694)**

Reclining Chair

The SuperLoafer Chair is an improved model of the BarcaLoafer with frame of anodized aluminum for light weight, attractive appearance and ease of maintenance. The chair has a new 4 position gravity lock with no nuts, bolts or rivets at pivotal points. It weighs only 27 pounds and can be used as a wheel chair when placed on a specially designed wheeled under-carriage. When not needed, the chair is quickly and easily folded for storage.

The chair is especially designed for hospital use as an aid in the early ambulation of post-operative patients and in later convalescence. The balanced chassis of the chair can be moved from vertical to horizontal and back with little effort by the patient, thus giving him exercise without standing on his feet. The continuous washable cushion is covered with reenforced plastic which can be cleaned with a disinfectant solution and is resistant to sun, water, alcohol, oils, greases and acids. The SuperLoafer would also be an asset in sun rooms, lounges, nurses' homes and other personnel quarters for rest and relaxation. **Barcalo Mfg. Co., Dept. MH, Buffalo 4, N. Y. (Key No. 695)**

Microscope Illuminator

The new Spencer No. 735 Lamp has been designed for routine and advanced laboratory work to give correct microscope illumination. With efficient optics and precise, conveniently located mechanical controls, the lamp furnishes both Kohler and parallel illumination for bright field and phase microscopy, photomicrography, microprojection and dark field illumination.

The illuminator is designed for cool operation and the reflecting mirror is quickly and precisely adjusted at any time by means of 3 screws. Focusing can be done by either left or right hand and the lamp body may be separated for access to the interior parts by releasing 2 thumb screws. The new No. 735 may be obtained with or without an iris diaphragm and with single or multiple filter holder attachment. **American**



Optical Co., Dept. MH, Scientific Instrument Div., Buffalo 15, N. Y. (Key No. 696)

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

Model V-A Floor Machine

The new Model V-A floor machine is available with or without a solution storage tank mounted on the handle and is designed both for floor maintenance work and for shampooing rugs and carpets. A series of easily interchangeable attachments is available for converting the machine for scrubbing, waxing, polishing, buffing, sanding, grinding or steel wooling floors of all kinds.

The new machine utilizes a vertical gear reduction motor in a 1/3 h. p. machine with a 14 inch brush spread. The motor is of the brushless, capacitor-start type designed for rugged dependability. **Hild Floor Machine Co., Dept. MH, 740 W. Washington St., Chicago 6, (Key No. 697)**

Floor Machines

Two new models have been added to the line of Unico floor machines. Model SB14-A is equipped with a 14½ inch diameter brush for scrubbing areas up to 5000 square feet and Model SB16-A has a 16½ inch diameter brush for areas up to 7500 square feet. The new models are also available with attachments for waxing and polishing all types of floors, for steel wooling, machine troweling, abrasive grinding and finishing. Both models are equipped with the new GE motor and gear units designed for long, trouble free service, and with new rubber bumpers and rubber-coated, shockproof switch levers.

The company has also introduced two new rug scrubbing machines, Models CS14-A and CS16-A, with the same features and capacities as the floor scrubbing machines. They are equipped with tanks that feed shampoo solution for shampooing rugs and carpeting on the floor. **United Floor Machine Co., Dept. MH, 7600 S. Greenwood Ave., Chicago 19. (Key No. 698)**

Stainless Steel Mop Wringer



A new mop wringer, made of stainless steel for sanitation and ease of maintenance, has recently been announced. The wringing device on the new unit is designed for efficiency and ease of operation, a minimum effort producing a maximum of leverage. The new unit is neat in appearance, durable, rustproof and requires a minimum of maintenance. **Market Forge Co., Dept. MH, Everett 49, Mass. (Key No. 699)**

Gray Magic Royal Typewriter

The new Royal typewriter, known as the Gray Magic, is finished in a new soft gray tone developed by Royal to give added eye comfort to the operator by elimination of glare. An interesting feature of the new Gray Magic Royal is the shape of the keys. Known as "Finger-Flow Keys," they are flat in front, thus reducing the possibility of catching the key above when typing, and permitting more space between the rows of keys. Keys have a concave surface, shaped to fit the finger exactly.

Easy removal of the cylinder with the thumb and finger of one hand for cleaning of the cylinder and feed rolls and



for changing in cases of special platen substitutions is another feature of the new Royal. Other important improvements include a non-slip paper feed and a newly-designed line space lever. The machine retains the "Magic" margin, "touch control," automatic paper lock, Time Saver Top and other advantages of careful construction, fine quality and ease of operation of the Royal line. **Royal Typewriter Company, Inc., Dept. MH, 2 Park Ave., New York 16. (Key No. 700)**

Stencils

The new Protect"O"Film is a new stencil with a clear, protective film designed to make stencil cutting easier, faster and more efficient. The elastic film covering keeps letters in place to produce uniformly perfect copy and protects against type filling. The film is easily lifted away from the stencil to make corrections. Both Royal Blue and Lettergraph brands of stencils are available with Protect"O"Film. **The Heyer Corp., Dept. MH, 1850 S. Kostner Ave., Chicago 23. (Key No. 701)**

Redesigned Autopan Bed



The "American" Autopan Bed has been redesigned for greater efficiency and more comfort for the patient. The new model of the bed, for servicing the bedpan within the bed itself, is now available.

A crank handle, conveniently positioned adjacent to the point of bedpan removal, is turned to elevate the head mattress section supporting the patient at the lumbar arch. The newly designed center mattress sections depress and move laterally in opposite directions as the bedpan is elevated into position beneath the patient. The head mattress section then lowers to the normal level, placing the patient in proper position in contact with the bedpan. Turning the crank in the opposite direction reverses the cycle, removing the pan and returning the patient to his original position. Catching the patient in the closing mattress sections is avoided by their automatic approximation below the mattress level before moving upwards. **American Sterilizer Co., Dept. MH, Erie, Pa. (Key No. 702)**

Improved Magikan

The Magikan step-on waste container has been improved in design and operation. The Model 100 has an outer housing and lid of heavy gauge treated steel finished in baked enamel in white, red, yellow or black. The 15 quart capacity removable inner container is made of heavy gauge galvanized steel. The lid is fitted with a smooth rubber cushioned trip to eliminate noise.

Models 200, 300, 400 and 500 Magikans have outer housing and lid of unpainted satin finish aluminum or heavy gauge treated steel enameled in the same colors as Model 100. The removable 20 quart inner container is finished in aluminum or heavy galvanized steel. All models have the "Air Wing" toe control for opening the cover which remains open until released, and the squared design with rounded corners for easy cleaning. **Binswanger-Henkin Industries, Dept. MH, 641 Union Ave., Memphis 3, Tenn. (Key No. 703)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

Faucet Rebuilding Unit



Permanent repair or rebuilding of faucets is now possible with the new Sexauer No. 100 Giant "Handy Andy" assortment. Containing 1080 Sexauer parts, the assortment is housed in a sturdy, compartmented, steel kit with locking cover and carrying handle for ease in transporting to place of need. Included in the assortment is a properly balanced stock of everything needed to rebuild any type faucet and many small valves. It saves time and effort in maintenance and makes it possible to do a complete job instead of making a temporary repair. **J. A. Sexauer Mfg. Co., Inc., Dept. MH, 2503 Third Ave., New York 51. (Key No. 704)**

Cold Air Control

Air Sentry is the name of an automatic cold air control for installation in windows of patients' rooms to prevent undue chilling while providing fresh air for ventilation. It is a self-contained unit, requiring no extra wiring or mechanical connections. A canopy inside the Air Sentry is opened or closed automatically by action of a thermostat which controls the amount of cold air entering the room. The unit is easily installed, the temperature can be adjusted to suit the occupant of the room, and there are no maintenance costs for the product. **Air Sentry Co., Dept. MH, 631 E. Center St., Milwaukee 12, Wis. (Key No. 705)**

Air Freshener

Air-aid is designed to freshen and deodorize the air quickly and safely. It is described as a fluid that is safe, non-toxic and non-inflammable and is colloidally dispersed so that it evaporates evenly, removing staleness and odors from the air. It can be applied to any new or existing air conditioning or mechanical ventilation system by means of a simple automatically fed evaporator containing no moving parts. For non-air conditioned spaces containers with individual evaporators are available. **Air Correctives, Inc., Dept. MH, 441 Lexington Ave., New York 17. (Key No. 706)**

Patients' Signal System

After a detailed study of the abuses and hazards to which a patients' calling station can be subjected, a new patients' low voltage type calling station has been developed which is designed to overcome all hazards. The locking button is enclosed in a practically unbreakable molded shell; the button is long and easily operated by the patient; the reset collar is large in area; all contacts are heavy duty with positive wiping action; contact mechanism is positive-lock construction, and the cord is connected to the mechanism by screw terminals and a strain relief anchor, thus ensuring that cord pull will not disturb the connection.

Another new product developed by the same company as part of the new Auth Vokacall System is the portable Microphone-Speaker No. 222 which is de-



signed to be placed at the patient's bedside so that he can communicate with the nurse's control station and so that the nurse, when desired, can listen to the patient and to room noises for supervision from her desk. The new unit is small, neat in appearance and can be quickly plugged into the special receptacle in the patient's calling station. When connected to an electronic Nurse's Signal Control Station it permits easy two way voice communication between patient and nurse. **Auth Electric Co., Inc., Dept. MH, 34-20 Forty-Fifth St., Long Island City 1, N. Y. (Key No. 707)**

Examining Gastroscope

The new A.C.M.I. Flexible Examining Gastroscope has an optical system designed to provide a flat 56 degree visual field free from distortion. The new lens system provides clear vision at highly bent angles and is fully corrected for color, spherical aberration and coma. An adjustable eyepiece permits sharp focusing. **American Cystoscope Makers, Inc., Dept. MH, 1241 Lafayette Ave., New York 59, N. Y. (Key No. 708)**

Insecticide Microsols

The Microsol No. 202 is a compact, portable unit designed to produce a continuous aerosol fog primarily used for dispersion of insecticide concentrates but also for dispersion of germicides, deodorizers, air-refreshers, sterilizing agents and other liquids. The compact unit is powered by a full ¼ h.p. universal motor which is air cooled and which requires no maintenance. An electrically-powered centrifuge breaks down the insecticide material into microscopically fine particles light enough to be airborne and projects them in the form of an aerosol fog which filters into cracks, crevices and inaccessible areas. The unit employs no extraneous materials in forming the fog, can be operated by unskilled personnel and treats an average sized room in 15 seconds. The Microsol No. 202 is manufactured by The Hession Microsol Corp. and is distributed by **The Mitchell-White Corp., Dept. MH, 12 E. 22nd St., New York 10. (Key No. 709)**

Stainless Steel Food Container

The new Solar stainless steel food container has been designed for convenient, sanitary storage of food in storerooms, refrigerators and other locations and for transportation from a central kitchen or between buildings. The seamless construction leaves no crevices or edges where food can lodge, body and bottom are one unit, and the cover has a stainless steel spring that, when pushed down into place, grips the inside of the neck firmly and protects the contents of the container from air contamination.

The stainless steel handles are designed for ease in carrying and in pouring and the wide mouth permits easy removal of stored food by pouring or ladling. A 1½ inch bottom band of heavy gauge stainless steel reenforces



the container and raises it ½ inch off the floor. **Solar-Sturges Mfg. Co., Dept. MH, Melrose Park, Ill. (Key No. 710)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

Machine Dishwashing Compound

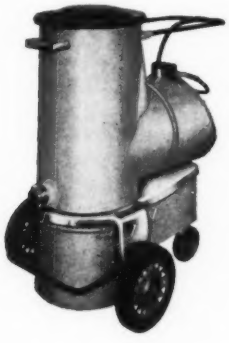
The formula of Wyandotte Keego, the compound for machine dishwashing, has been improved to increase its capacity for washing in water containing hardness due to calcium or magnesium salts. The desirable properties of the original formula—mildness to silverware, protective action on interior fittings of machines, high suspending power for food residues, free rinsing and the ability to remove many types of stains from chinaware—have all been retained, thus making the product especially effective for machine dishwashing. **Wyandotte Chemicals Corp., Dept. MH, Wyandotte, Mich. (Key No. 711)**

Two Cylinder Truck

Designed to cut transportation time for the delivery of oxygen cylinders, the new 4 wheel two-cylinder O.E.M. Safeguard Truck is mounted on 2 heavy duty 8 inch front tires and two 3 inch ball-bearing rear casters for noiseless and easy mobility. Made of all welded steel, the truck is equipped with completely retractable rear wheel assembly for minimum storage space. A spring locking device assures safety at whatever angle the truck may be adjusted. A beveled platform facilitates loading and unloading. **Oxygen Equipment Mfg. Corp., Dept. MH, 405 E. 62nd St., New York 21. (Key No. 712)**

Mobile Vacuum Cleaner

The Spencer Commercial Vacuum Cleaner is designed for fast, complete cleaning of all kinds of surfaces. It will clean rooms, offices, corridors and other areas and is built for continuous service over the years at low maintenance costs. The unit is powered by a universal motor having a continuous



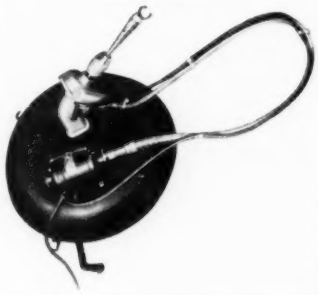
rating of ¾ h.p. and a dirt can with a capacity of .875 cubic foot which is easily removed by a foot operated bar and rolled on its own casters to the point of disposal.

The machine is readily portable by the hand rail at the top, or a pull on the hose. It operates for long periods without loss of vacuum and the bag is cleaned without removal from the tank. Attachments permit use of the machine for the various cleaning needs. **The Spencer Turbine Co., Dept. MH, 484 New Park Ave., Hartford 6, Conn. (Key No. 713)**

Floor Patch

Tampatch is a new fast drying floor patch designed for making rapid repairs to concrete floors without the necessity of closing off the area being treated. The product is supplied in ready mixed form, and is designed for interior or exterior use. **United Laboratories, Inc., Dept. MH, 16801 Euclid Ave., Cleveland 12, Ohio. (Key No. 714)**

Drain Cleaner

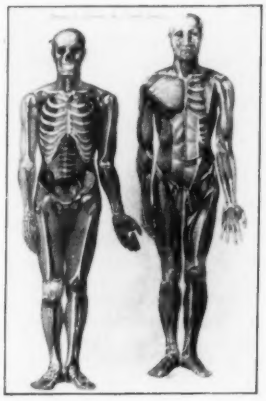


A new wasteline and drain cleaning machine has been developed which eliminates dirt and water on floor and clothing and ensures operator safety. The double cable container has an inner drum which rotates on ball-bearings within the stationary outer drum. Power is transmitted to the gun through the flexible power cable from a reversible 1/6 h.p. universal motor. Tools are provided for cleaning lines from 1¼ to 4 inches in size. **The Ohio Tool & Engineering Co., Dept. MH, 128 N. Spring St., Springfield, Ohio. (Key No. 715)**

Insecticide

A new insecticide has been announced which employs the recently developed insecticidal chemical, Chlordane, with pyrethrins and organic theocyanates. Known as Gulfspray Roach and Ant Killer, the product has proved highly successful in the extermination of roaches and has a residual effect as high as six months. **Gulf Oil Corp., Dept. MH, 3800 Gulf Bldg., Pittsburgh 30, Pa. (Key No. 716)**

Skeleton and Circulation Charts



A series of anatomy charts, the originals of which were done in oil by P. M. Lariviere, is now available from Denoyer-Geppert. The first of the series shows the front and back views of the skeleton and muscles in almost life size with the ligaments on one side. The skeletal reproduction on the left and the muscular development on the right of the same chart, make it possible for students better to appreciate the intimate relationship of these structures to one another.

Two charts showing circulation are also almost life size and portray the arterial and venous system in one chart and the scheme of circulation, portal circulation and capillaries in another. All figures are drawn against a light blue background to accentuate the anatomical detail. The charts are available with plain rollers top and bottom or with spring roller mounting. **Denoyer-Geppert Co., Dept. MH, 5235 Ravenswood Ave., Chicago 40. (Key No. 717)**

Paper Cup Dispenser

A new recessed water cup dispenser for use with paper cups has recently been developed. Designed to be mounted flush with the finished wall surface, the dispenser cannot be broken or removed from the wall. Made of metal with a clear plastic window to indicate when in need of refilling, the dispenser is available in satin-chrome finish or in prime paint finish. Mechanically foolproof, it contains no weights, springs or other movable parts and can be adapted for use with 4 sizes of flat-bottom Dixie Cups and 2 sizes of cone-shaped Dixie or Vortex cups. Designed for installation in new hospitals, it can also be installed with relative ease in existing hospitals as part of a modernization program. **Dixie Cup Co., Dept. MH, Easton, Pa. (Key No. 718)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

Nasopharyngoscope

The new National Nasopharyngoscope has the new Fontar lens system which permits a closer, larger view of eustachian orifices, the nasal floor and a more complete inspection of mucous membranes, blood vessels, posterior portions of the turbinates and the posterior pharyngeal wall. Tissue extremely near or in contact with the lens can be viewed with brilliance. The new, patented flange feature simplifies lamp removal and replacement and the new instrument has full 360 degree circle of right angle vision. It is furnished with a newly developed small battery handle or with a switch cord for operation from standard light transformers. **National Electric Instrument Co., Inc., Dept. MH, Elmhurst, L.I., N.Y. (Key No. 719)**

Toilet Brush Holder

A sanitary, convenient holder for wet toilet bowl brushes, which eliminates dripping on the floor and keeps the brush from matting has been developed in rustproof steel, bonderized and enameled white. Known as the Sanhold, the device is durable and keeps the brush suspended until ready for use. **Upper Midwest Specialties Co., Dept. MH, Mankato, Minn. (Key No. 720)**

Water Bath

The new streamlined National Constant Temperature Water Bath is a double-wall, stainless steel, thermostat-controlled water bath designed to keep temperature constant within ¼ degree, plus or minus. It is insulated with fiber glass and has a V-shaped trough at the bottom of the bath which sets up convection currents to keep the temperature uniform throughout. It is available in all standard water bath sizes. **National Appliance Co., Dept. MH, Swan Island, Portland 18, Ore. (Key No. 721)**

Socket Protector

Designed to provide maximum protection against breakage of lighting sockets, the Ajusco-Loc socket protector can be used on most medium base brass shell sockets. A solid die-cast socket cap with a minimum wall thickness of 3/64 inch, a 16 gauge steel ring and 3 brass screws, the assembly is easily and quickly attached to the socket and should cut replacement costs of sockets and wiring, reduce danger of blown fuses, electrical shock and fire caused by twisted wires and broken splices and reduce or eliminate time spent in socket repairs. **Adjustable Fixture Co., Dept. MH, 104 E. Mason St., Milwaukee 2, Wis. (Key No. 722)**

Pharmaceuticals

Stigminene

Stigminene Bromide Warner is a new cholinergic compound of low toxicity and prolonged action. It is developed for use in the prevention and treatment of postoperative abdominal distention and urinary retention and is supplied in 1cc. ampules of a 1:2000 solution, 0.5 mg. each. **William R. Warner & Co., Inc., Dept. MH, 113 W. 18th St., New York 11. (Key No. 723)**

Soltabs

Soltabs is the new trade name for Soluble Tablets Crystalline Penicillin G Potassium. In addition to the 50,000 unit tablets previously available, Soltabs are now also available in 100,000 unit tablets. These compressed tablets contain neither binder nor excipient and are readily soluble. **C. S. C. Pharmaceuticals, Division of Commercial Solvents Corp., Dept. MH, 17 E. 42nd St., New York 17. (Key No. 724)**

Abergic Tablets

A new group of products known as Abergic Tablets has been developed by Upjohn to supply the need for a line of common pharmaceuticals which may be prescribed for patients suffering from food allergy. The inert ingredients in the new line of tablets are selected from materials which are either non-allergenic or not likely to cause allergic reactions. Many Upjohn products are now available in the new form. **The Upjohn Company, Dept. MH, Kalamazoo 99, Mich. (Key No. 725)**

Chlorothen

Chlorothen is a new antihistaminic designed to give long-acting relief from allergic symptoms, particularly seasonal hay fever. Side effects are said to be mild, when they do occur. It is supplied in uncoated tablets of 25 mg. each in bottles of 100. **Whittier Laboratories, Dept. MH, 4210 Peterson Ave., Chicago 30. (Key No. 726)**

Pyribenzamine Ephedrine Tablets

Pyribenzamine Ephedrine Tablets are an antihistaminic with a sympathomimetic agent designed for effective and prolonged relief of allergic manifestations. Research with the new product has indicated a high percentage of improvement in asthma cases. Developed for oral administration, the product is supplied in bottles of 100 tablets. **Ciba Pharmaceutical Products, Inc., Dept. MH, Summit, N.J. (Key No. 727)**

Pen-Aqua

The addition of water or isotonic solution of sodium chloride to Pen-Aqua, according to label instructions, provides a suspension containing 300,000 units per cc. of crystalline procaine penicillin G and 100,000 units per cc. of buffered crystalline penicillin G potassium. The product is designed to attain penicillin blood levels which are usually greater than the therapeutic requirement immediately after injection with a subsequent lower level which extends for a period of 24 hours in most patients. **Bristol Laboratories, Inc., Dept. MH, Syracuse 1, N. Y. (Key No. 728)**

Furacin Ear Solution

Furacin Ear Solution, anhydrous, contains 0.2 per cent Furacin in a bland, penetrating, hygroscopic, water-miscible liquid vehicle composed of polyethylene glycol, and was developed for the treatment of both acute otitis and cases of refractory, chronic otitis. Furacin Eaton brand of nitrofurazone N.N.R. is a synthetic antibacterial agent effective against the majority of organisms found in surface infections. The new ear solution is supplied in dropper bottles of 30 cc. **Eaton Laboratories, Inc., Dept. MH, Norwich, N. Y. (Key No. 729)**

AVC Improved

National Drug Company's Allantomide Vaginal Cream is now available in a new formula. AVC Improved is specific for vaginal trichomoniasis and is also effective in the treatment of moniliasis. It is superior to the old formula, according to the manufacturer, in the treatment of vaginitis due to mixed infections and contains sulfanilamide 15 per cent, 9-aminoacridine 0.2 per cent and allantoin 2 per cent. The improved non-staining, non-irritating water-miscible cream is supplied in 4 ounce tubes packaged with or without applicator. **National Drug Co., Dept. MH, 4663 Stenton Ave., Philadelphia 44, Pa. (Key No. 730)**

Hormone Buccal Tablets

Cortate Buccal Tablets are hormone tablets with a polyethylene glycol base designed for the utilization of the parenterally effective hormones through absorption from the buccal pouch of the mouth. Polyhydrol, the base, is the result of seven years of research to permit hormones to be absorbed directly into the systemic circulation. Also available for buccal therapy, with the same base, are tablets of Progynon, Oreton and Proluton. **Schering Corporation, Dept. MH, Bloomfield, N. J. (Key No. 731)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

Pertussis Vaccine Phase I Alhydrox

Pertussis Vaccine Alhydrox-Cutter is a new immunization agent developed to provide for a delayed rate of absorption and an enhancement of the antigenic properties for active immunization against whooping cough, especially in infants. Each cc. of the new product contains 30,000 million H. pertussis organisms. **Cutter Laboratories, Dept. MH, Berkeley 1, Calif. (Key No. 732)**

Dihydrostreptomycin

Dihydrostreptomycin, the new streptomycin derivative used in the treatment of tuberculosis and found to have fewer unfavorable reactions, is now being produced by Merck and Company. This highly purified antibiotic, chemically distinct from streptomycin, has proved especially useful in cases requiring relatively high dosage. It can be used interchangeably for intramuscular therapy with streptomycin calcium chloride complex Merck and other forms of streptomycin. **Merck & Co., Inc., Dept. MH, Rahway, N.J. (Key No. 733)**

Abbott Deciliters

Abbott Deciliters for pediatric use each contain 100 cc. with Goldy seal. The solutions are sterile and free from pyrogenic substances and the Deciliters are designed to reduce the waste involved in the partial use of larger containers and to eliminate the danger of contamination and reactions sometimes encountered when repeated infusions are made from a single large container. Products available in this form include Isotonic Sodium Chloride, U.S.P.; Dextrose, U.S.P. 2½ per cent w/v in Hypotonic Sodium Chloride Solution; Lactated Ringer's Solution, U.S.P.; Dextrose, U.S.P. 2½ per cent w/v in Lactated Ringer's Solution, and Sodium r-Lactate, 1/6 Molar. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 734)**

Soluthricin Concentrate

Soluthricin Concentrate is a new form of tyrothricin concentrate which is readily soluble in aqueous solution. The product is indicated in the treatment of ulcers of the extremities, abscesses of the skin and soft tissues, ophthalmic infections and similar conditions. It must be diluted with sterile distilled water before use and application of appropriate dilutions may be accomplished by continuous or intermittent wet dressings, by drop, spray or irrigation, and by instillation into cavities not connected directly with the blood stream. **Sharp & Dohme, Inc., Dept. MH, Philadelphia 1, Pa. (Key No. 735)**

Product Literature

• An attractive and practical new 72 **page Catalog** has been issued by Simmons Company, Merchandise Mart, Chicago 54, illustrating and describing the Simmons line of mattresses, beds, metal furniture, cribs and orthopedic equipment. Two pages of decorator-suggested color schemes especially planned for hospital rooms and giving color suggestions for walls, ceiling, woodwork, floor covering, draperies, bedspreads and furniture upholstery; complete instructions for the operation of the Deckert Multi-Position spring; suggested arrangements of furniture in nurses' quarters, one and two bed hospital rooms and a pediatric unit; uses of the self-adjusting bed; hospital room groupings shown in color and decorated with the principles of color therapy in mind and an entire section devoted to orthopedic equipment showing 3 types of Balkan frames: permanent, demountable and portable, are some of the items covered which make Catalog 25 an important reference and planning manual for the hospital administrator and his department heads. **(Key No. 736)**

• **"Royalsteel Distinctive Metal Furniture"** is the title of an attractively laid out and printed 16 page catalog published by Royal Metal Mfg. Co., 175 N. Michigan Ave., Chicago 1. In addition to excellent photographic illustrations of these arm chairs, executive chairs, side chairs, tables, settees and costumers, the descriptive information gives details of the precision construction of this steel furniture. **(Key No. 737)**

• The 1948-49 edition of **"Milk Facts,"** a booklet issued by the Milk Industry Foundation, Chrysler Bldg., New York 17, should prove of interest to administrators as well as to dietitians. The booklet contains such facts as the number of milk cows in the various states of the country, milk production, farm income, how the milk supply was used, value of milk in the diet, who gets the consumer's dollar, how it is used and other interesting data. **(Key No. 738)**

• Complete information on the line of **"Standard American Aseptible Furniture for Physicians' Offices and Hospitals"** is given in Catalog No. 149 recently issued by American Metal Furniture, Inc., Indianapolis 7, Ind. A general description of construction and materials and the policies of the company precedes the well presented catalog information on operating, examination and treatment tables, chairs, stools, stands, bedside tables, screens, cabinets, utensils, chart desks, dressing carriages, wheel stretchers and other equipment and supplies manufactured by the company. All items are listed in an alphabetical index. **(Key No. 739)**

• A new 78 page **Catalog and Service Book** of surgical dressings and supplies has recently been issued by Johnson & Johnson, New Brunswick, N. J. Containing information on and illustrations of approximately 300 different products, the catalog features a section giving suggestions for economies in hospital administration without sacrifice of standards. Entitled "How to Save on Surgical Dressings," the section makes concrete recommendations. The new book is attractively bound with a glazed cover to resist soiling. **(Key No. 740)**

• A booklet on **"Central Oxygen Piping System for Hospitals"** has been released by the Ohio Chemical & Mfg. Co., 1400 E. Washington Ave., Madison 10, Wis. Fully illustrated with photographs and typical floor plans, the booklet includes descriptions of small installations, bulk systems and trailer systems. **(Key No. 741)**

• The first issue of Blickman **"Trends,"** a bulletin of new developments in hospital and institution equipment, was presented by S. Blickman, Inc., Weehawken, N. J., in March. Developed for monthly publication, the bulletin is designed to furnish administrators and other hospital executives with helpful information regarding equipment designed to meet current developments in therapy and service. **(Key No. 742)**

• Those planning new hospitals or the remodeling of showers, cafeterias, corridors, stairways or an entire building, will find helpful information in the new **Marlite Sample Folder** issued by Marsh Wall Products, Inc., Dover, Ohio. Actual color samples of Marlite, the plastic-finished wall and ceiling panel, and swatches to indicate the many colors in which the product is available, are included in the folder. A hospital operating room is one of the typical installations illustrated. **(Key No. 743)**

• **"Portion Control and Food Cost Manual,"** by George L. Wenzel, food expert, is a 52 page booklet published under the sponsorship of the Paper Cup and Container Institute, Inc., 1790 Broadway, New York 19. Designed to effect savings in food service, the booklet contains tables of suggested portion sizes and costs for various food items. Single copies are available to food service managers at no cost although the manual carries a price of $1. **(Key No. 744)**

• A new catalog on **Ellison Balanced Doors** has been issued by Ellison Bronze Co., Inc., Jamestown, N. Y. Photographs and drawings illustrate the details of these doors as well as many installations. Full descriptive information is supplied together with a list of authorized representatives. **(Key No. 745)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

• Information on Dial Soap, of interest to hospital administrators, nurses, physicians and department heads, is presented in a booklet entitled **"A Germicidal Soap —Its Significance to the Medical Profession,"** and published by Armour & Co., 1355 W. 31st St., Chicago 8. A discussion of the presentation of Dial Soap as a deodorant soap to the general market is followed by information on research including photographs of tests of germicidal effectiveness, toxicity and irritation data and professional applications, with a bibliography of medical references to G-11 soaps. **(Key No. 746)**

• **"The 'Lusterized' Glass Entices Appetites"** is the title of a new booklet published by the Olson Mfg. Co., Albert Lea, Minn. How legal regulations can be met in kitchen and fountain by the use of the Lusterizer, the portable Olson glass washer which fits any sink, is discussed in the booklet. Designed to turn out 700 to 800 clean glasses, devoid of lipstick or cloudy film, each hour with one operator, the Lusterizer also has a special brush for cleaning nursing bottles of various types, removing all milk film in the process. Details of operation of the Lusterizer are shown. **(Key No. 747)**

• Detailed information and specifications on the Cadillac chassis engineered especially for ambulance and funeral car use, and on the new Cadillac V-type valve-in-head motor used in the chassis are presented in an attractively laid out and printed booklet, **"Cadillac Commercial Cars and Chassis for 1949,"** issued by Cadillac Motor Car Division, General Motors Corp., Detroit 32, Mich. **(Key No. 748)**

• A folder describing **Diafoods,** soups, desserts and dressings developed for salt-free and sugar-free diets, has been issued by Diafoods division of Louis Milani Foods, Inc., 6058 S. Walker Ave., Maywood, Calif. Food values of each of the products in this line are given in charts presented in the folder together with prices. **(Key No. 749)**

• The full line of **Bennett Waste Receptacles,** featuring non-rusting stainless steel feet, is described and illustrated in a new catalog recently issued by The Bennett Mfg. Co., Alden, N. Y. **(Key No. 750)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
Editor, "What's New for Hospitals"

- ☐ 683 Hermann Operating Table
- ☐ 684 Putty and Accessories
- ☐ 685 Blood Typing Board
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- ☐ 689 Oil Fired Bakery Oven
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- ☐ 692 Duo-Cut Tile
- ☐ 693 Franklin Ambulance
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- ☐ 695 Reclining Chair
- ☐ 696 Microscope Illuminator
- ☐ 697 Floor Machine
- ☐ 698 Floor Machines
- ☐ 699 Mop Wringer
- ☐ 700 Gray Magic Royal Typewriter
- ☐ 701 Stencils
- ☐ 702 Redesigned Autopan Bed
- ☐ 703 Improved Magikan
- ☐ 704 Faucet Rebuilding Unit
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- ☐ 706 Air Freshener
- ☐ 707 Patient's Signal System
- ☐ 708 Examining Gastroscope
- ☐ 709 Microsol Insecticide
- ☐ 710 Food Container
- ☐ 711 Machine Dishwashing Compound
- ☐ 712 Two Cylinder Truck
- ☐ 713 Mobile Vacuum Cleaner
- ☐ 714 Tampatch Floor Patch
- ☐ 715 Drain Cleaner
- ☐ 716 Insecticide
- ☐ 717 Skeleton and Circulation Charts
- ☐ 718 Paper Cup Dispenser
- ☐ 719 Nasopharyngoscope
- ☐ 720 Toilet Brush Holder
- ☐ 721 Water Bath
- ☐ 722 Socket Protector
- ☐ 723 Stigminene
- ☐ 724 Soltabs
- ☐ 725 Abergic Tablets
- ☐ 726 Chlorothen
- ☐ 727 Pyribenzamine Ephedrine Tablets
- ☐ 728 Pen-Aqua
- ☐ 729 Furacin Ear Solution
- ☐ 730 AVC Improved
- ☐ 731 Hormone Buccal Tablets
- ☐ 732 Pertussis Vaccine
- ☐ 733 Dihydrostreptomycin
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- ☐ 737 "Royalsteel Furniture"
- ☐ 738 "Milk Facts"
- ☐ 739 Catalog No. 149
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- ☐ 742 Blickman "Trends"
- ☐ 743 Marlite Sample Folder
- ☐ 744 "Portion Control Manual"
- ☐ 745 Ellison Balanced Doors
- ☐ 746 Dial Soap
- ☐ 747 "Lusterized Glass"
- ☐ 748 "Cadillac Cars and Chassis"
- ☐ 749 Diafoods
- ☐ 750 Waste Receptacles
- ☐ 751 Books

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MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc.
919 N. Michigan Ave., Chicago 11, Ill.

Book Announcements

W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. Bolduan and Bolduan, "Public Health and Hygiene," a Students' Manual, 4th Ed., 423 pp., $4.25. Brownell, "A Textbook of Practical Nursing," 3rd Ed., 465 pp., $3.75. "1949 Current Therapy," edited by Conn, 672 pp., $10. Fine, "Care of the Surgical Patient," 544 pp., $8. Jamieson and Sewall, "Trends in Nursing History," 3rd Ed., 632 pp., $4.50. McLester, "Nutrition and Diet in Health and Disease," 5th Ed., 800 pp., $9. Price, "The American Nurses Dictionary," 656 pp., $3.75. **(Key No. 751)**

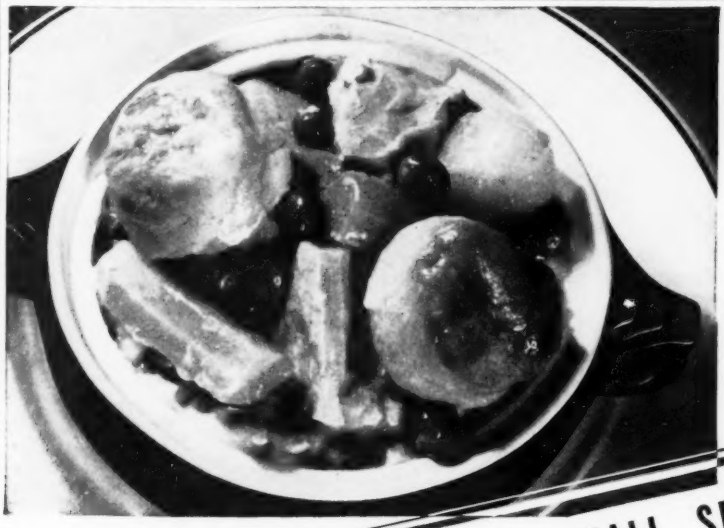
Suppliers' News

Cochrane Corporation, 3132 N. 17th St., Philadelphia 32, Pa., announces the acquisition of substantially all of the capital stock of **Liquid Conditioning Corp., Linden, N. J.** The latter company, manufacturer of a complete line of equipment for the conditioning of water and other liquids, will operate as a wholly owned subsidiary of Cochrane Corporation but will continue to market its products under the trade name "Liquon."

General Slicing Machine Co., Inc., manufacturer of kitchen machines, announces change of location from 100 S. Third St., Brooklyn 11, N. Y., to **Walden, N. Y.**

Organon, Inc. is the new name of the company formerly known as Roche-Organon, Inc., Nutley 10, N. J. Under the new name the company is continuing its manufacture of fine pharmaceuticals at **Orange, N. J.**

Printed in U. S. A.



Delicious
TWIN CITY CHICKEN PIE

Named in honor of the two big cities where hearty appetites and appreciation for fine food go hand-in-hand, this nutritious chicken casserole recipe has all the requisites to arouse lagging appetites. Easy to prepare perfectly . . . by baking 10-15 minutes in a scientifically designed, fireproof Hall casserole. Easy to serve perfectly . . . for gleaming, crazeproof Hall China seals in pure flavor and holds the heat.



"New Recipes in **HALL SECRET PROCESS CHINA** *Relieve Menu Monotony and Aid in the Control of Food Costs"*



Extra Dividend for Hall China Users!

Hall baking dishes can be used for many purposes, other than the main course. For example . . . this eye and palate stimulating peach compote, browned in a Hall China sole dish, serves five persons at an extremely economical cost price. A tasty, healthful dessert, and it gives you an extra dividend on your investment in Hall China.

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